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VOLUME 57 · NUMBER 2
MONTREAL
FEBRUARY, 1961

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"What is Real Nursing?"

* * *

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Between Ourselves

What *is* real nursing? In this issue we are presenting the points of view on this theme of a half dozen authors from a variety of disciplines. Unlike our frequent practice, this did not start out as a series of articles that we had requested as parts of a whole. Rather, they are an indication of the concern to be found in many walks of life respecting nursing. With the exception of the article by Doctors Benne and Bennis, which is reprinted from the *American Journal of Nursing*, each was submitted separately, for possible publication, within about two months of the others. The suggestion that we secure permission to reprint the *AJN* article was received in that same interval, nevertheless.

We feel that the very fact that this interest, this concern is evident from so many areas is a very salutary thing for our profession. There is nothing more deadly, more suffocating than complacency and indifference, especially where matters of professional significance are concerned.

Many years ago a prominent worker in the public health field asserted that "no one understands another person who has not the ability *through the fingertips* to receive and give messages of faith and comfort." How can nurses maintain this "finger-tip" contact with the people of every age group who come to the hospitals, the outpatient departments, the community clinics, the folk who come for help, if every possible function is shifted over to someone less well trained, less highly skilled? That contact is the Grail that Miss Keeler holds aloft. It is the glimpse seen in Father Troy's backward glance. It is the answer to the need for change Mr. Ruys suggests. It is real nursing.

* * *

We tend to use the words "health" and "hygiene" as if they were completely interchangeable. For instance, we may speak of mental hygiene and mental health as if they were one and the same thing. Actually, the latter is only a part of the former. The dictionary defines health as "physical, mental or moral soundness; freedom from disease." Hygiene includes all of that and more. It is "the science of the preservation of health and the prevention of disease." To make it less static, we would add "and promotion" after "preservation" in that definition.

Every nurse is familiar with much of the ordinary information regarding oral health. She knows that a normal child should have its full complement of 20 temporary teeth by the time it is 30 months old. She knows a little about the value of the fluoridation of water as a preventive measure in dental caries. She knows, from personal experience, the value of regular visits to her dentist. She may even be able to identify the six-year molars, know about the importance of the cuspids as anchor teeth for the fitting of dentures, understand the seriousness of gum infections. We hope that her store of information will be markedly increased after reading the three excellent articles relating to dental hygiene in this issue.

* * *

Recently, a letter from a student nurse made us wonder where people get the curious notions that the writer indicated. We might have included the following excerpt among our "Random Comments" but we felt a fuller explanation really belonged here. "I think you should know that there is a general feeling here that your subscribers *have* to be graduate nurses." The writer suggested that if this was a "misapprehension" perhaps some clarification could be given.

Although there are some 15,000 student nurses in Canada, only about 18 per cent of them do subscribe to the *Journal*. Perhaps, therefore, someone needs to do some "clarifying." We can attempt it here but the chances are good that the student nurses, for whom the explanation is intended, will never see it. We appeal to instructors in the schools of nursing all across the country, therefore, to draw their students' attention to the following remarks.

1. There is no restriction of any kind on who may subscribe to the *Journal* — either in English or French as they desire. This means that *anyone* who pays the appropriate subscription price — graduate nurses, student nurses, nursing assistants, first aid workers, parents of students — anyone may subscribe.

2. To encourage student nurses, (whose bank accounts seldom are very large) to become thoroughly familiar with what is going on in our profession, special rates have been in effect since before most of these lassies — and lads — were born. The students themselves

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Random Comments

Dear Editor:

This is a belated reply to the letter written by Jane Lewis of Manitoba, that appeared in the September issue.

I trained in England from 1934 to 1938. We were taught to use a Castille soap in the treatment of bedsores. The soap was rubbed into the skin until dry, then the area was dusted with talc. We were told that the rubbing restored circulation, the lack of which had caused the bedsore.

ELLEN CHABOT, Quebec

Dear Editor:

While sending you my change of address I would like to extend my sincerest wishes for continued success with the *Journal*. I am sure I hold the opinion of hundreds of nurses, when I say the book is most exhilarating and ever interesting to read.

JACQUELINE E. MAZUR, Manitoba

Dear Editor:

In January, 1960 I registered in the province of Quebec and paid the required fee. Two months later I decided to travel across Canada to work in one of the western provinces.

Securing my registration in this province was a headache, although I had no great problem. I might as well have come from a hospital in a foreign country. I not only had to produce my registration for the current year, but also my birth certificate, high school leaving and matriculation marks, a letter from my school of nursing plus a record of the hours I had spent in theory and clinical practice, and in addition, twenty-eight dollars.

Thinking this to be all and enough, I visited the Placement Bureau of the RNABC and was required to fill out another three pages with the information I had given previously.

We are all nurses of Canada. If an R.N. who graduated from an accredited hospital goes to a similar hospital, why all this red tape?

In short, my plan would be that all nurses once graduated and duly registered, should be able to apply to a central bureau for what might be known as a "hospital passport." This passport could contain all the necessary information, a photograph of the nurse and an "okay" from her original Association. A nurse could then move more freely throughout her own country.

I have mentioned my idea to nurses who have travelled much more than I, as well as some doctors and they all feel that it is an excellent idea.

Of course, the procedure would be simplified if all Canadian nurses were required to write identical examinations for registration. If there was only one set of files which included information on every registered nurse in Canada, a nurse could request *one* letter from the registry to verify her standing.

If there is any rhyme or reason to what I have written, I would appreciate the points of view of nurses who know more about this than I do.

JESSICA RUSSELL, B.C.

Dear Editor:

I think the magazine is of the highest quality and feel that one can nurse more intelligently when one is well versed on the nation-wide progress of nursing and medicine. Thank you for a concise yet informative magazine.

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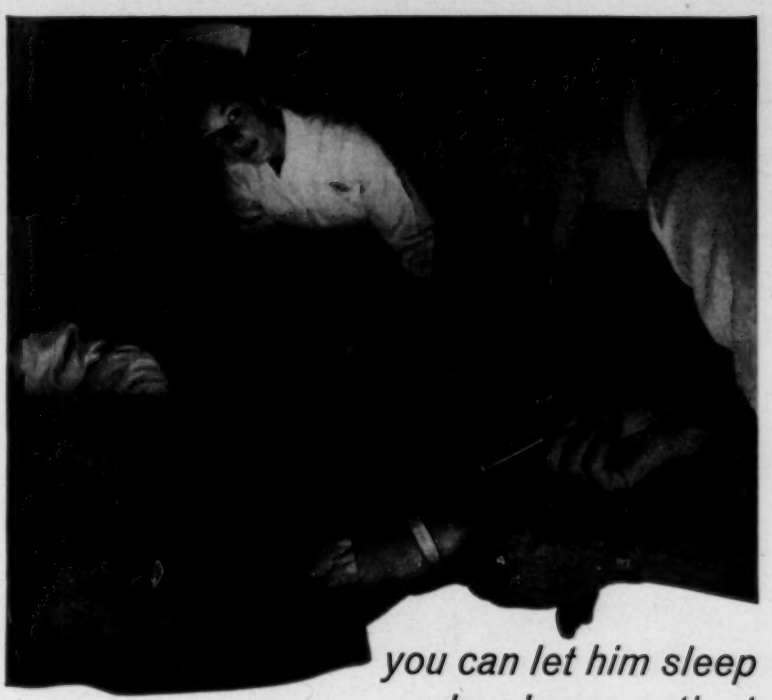

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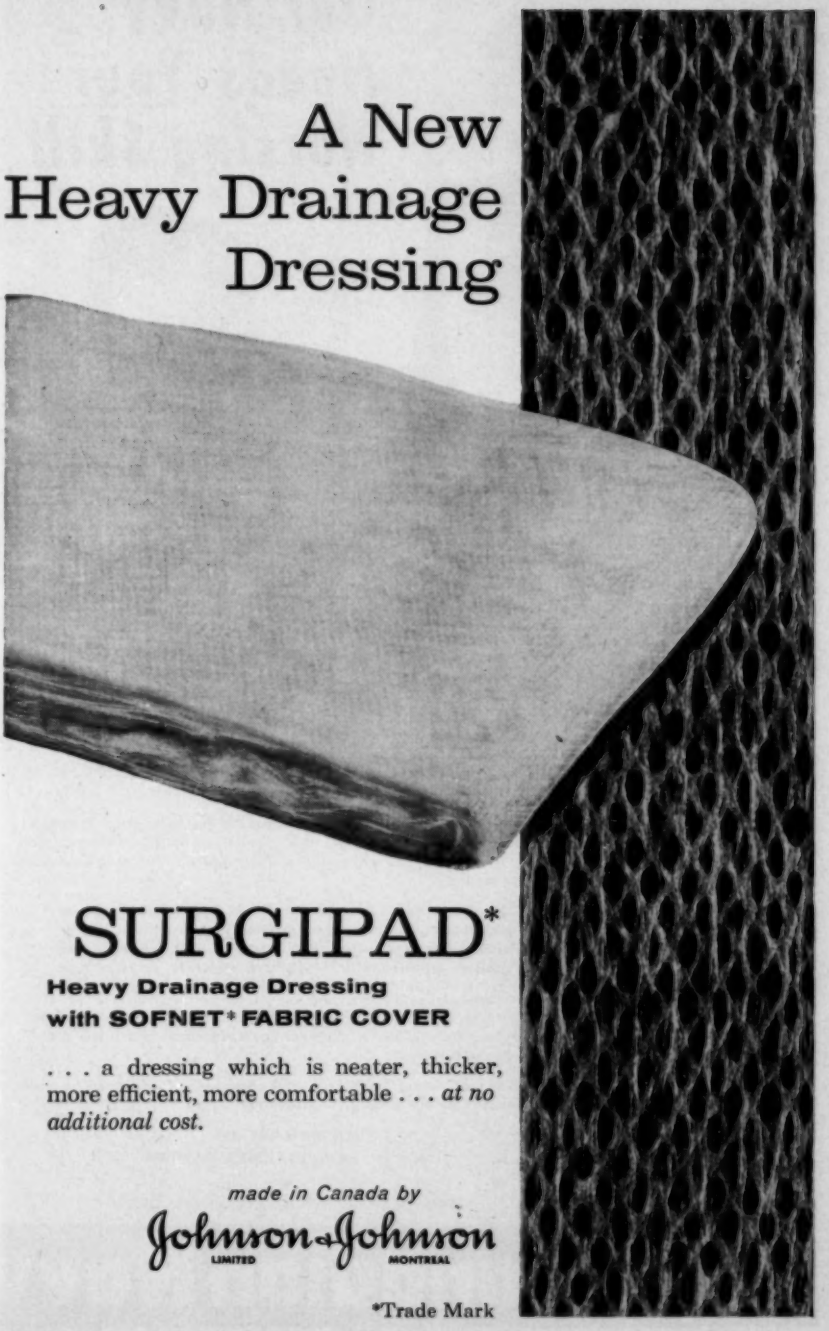

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*Niedelman, M. L. and Bleier, A.; Jour. Ped., 37:5, 762, Nov. 1950
Fischer, C. C. and Lipschutz, A.; Am. Jour. Dis. Child, 89:5, 596, May 1955
Benson, R. A., et al: Arch. Ped., 73:250 - 8, July 1956

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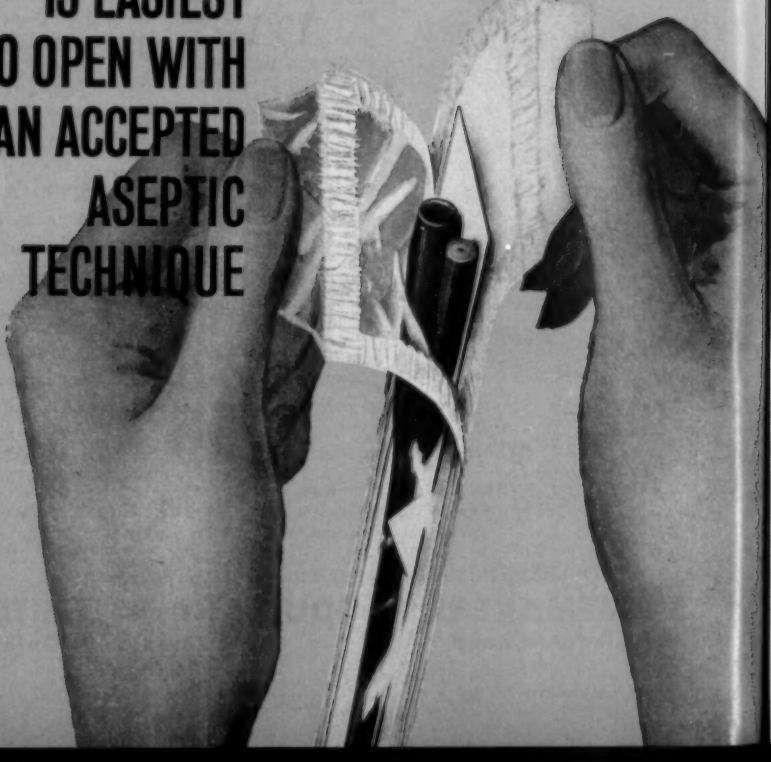

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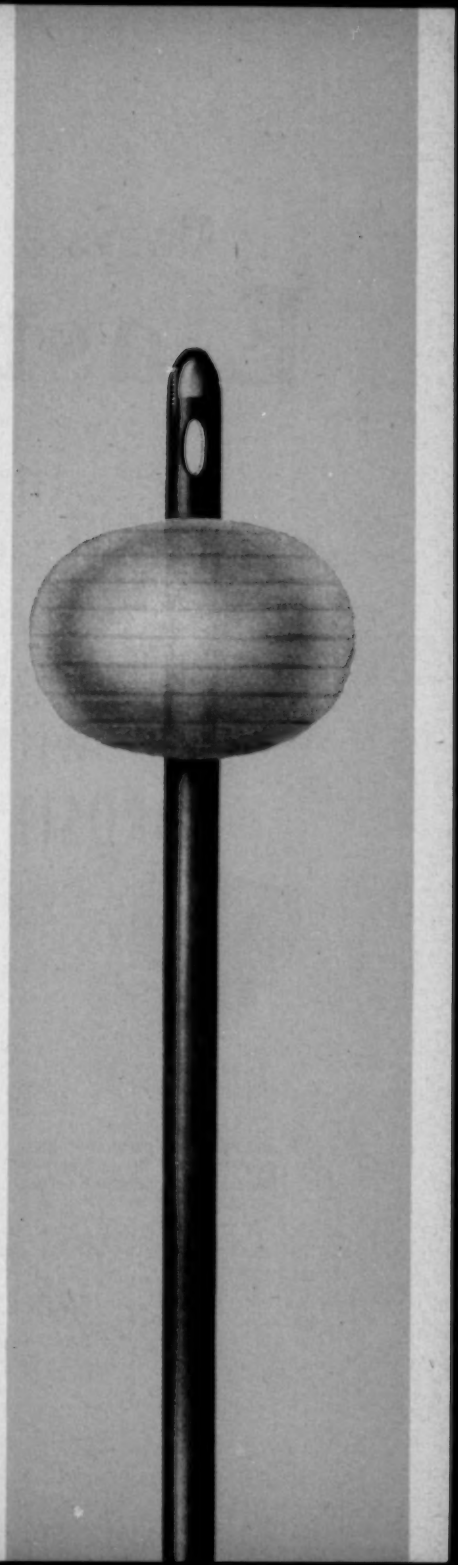

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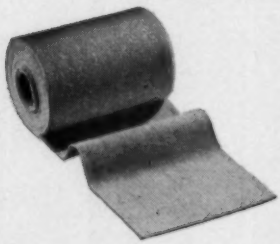

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VOLUME 57 NUMBER 2

MONTREAL, FEBRUARY 1961

Comprehensive Nursing Care

FOR A NUMBER of years the Macmillan Company of Canada has offered awards annually to student nurses who have written comprehensive nursing care studies. Perhaps it is redundant to say that in order to write a comprehensive nursing care study a nurse must have given that kind of care.

Both the Oxford Dictionary and Webster's Dictionary define comprehensive as "including much; having the power to comprehend many things; of wide mental grasp." The studies submitted comply with the first part of the definition; they include much. Some of them indicate that their writers comprehend many things. But what are the many things?

If we were to leaf through studies that have been published in our *Journal* we would find that in most of them there are several parts or sections. Each section has a heading such as, social history, medical history, tests, treatments, medications, nursing care and, more recently, at the *end* of the study, rehabilitation. The material in most of these sections has been taken from the patient's chart or from textbooks; information from the patient's chart is frequently derived from the

(Garcia)

PAMELA POOLE

activities of members of the health team other than the nurse.

In order to give comprehensive nursing care the nurse does need to comprehend many things. She needs to understand tests, treatments, medications. But does she understand them for themselves alone or is this knowledge necessary to the giving of care to a patient who is to have the tests, or receive the medications? Is technical knowledge of this kind all or only part of nursing?

> Nursing problems are related to, but apart from, medical problems . . . We have traditionally shared responsibility in the latter, through our observations and through delegated authority to administer medications, tests and treatments. Implicit even within these dependent activities, there is a large area for independent judgment.*

About what kinds of things does the nurse judge independently? Is it only in relation to tests, treatments and medications, or is nursing involved in other activities? Are these other activities merely made up of keeping the patient clean, adequately nourished and physically comfortable?

The primary value of knowing and understanding the patients' social history and medical history, and having an understanding of the tests, treatments etc., is so that the nurse can use this information in caring for a patient. When there is little or no reference to this material in the nursing care section, then it follows that either the information was not used to nurse the patient, or was not found useful to nurse the patient.

The same tests, treatments and medications could be part of the medical management of patients with a variety of diagnoses. They do not necessarily vary with the diagnosis, or with the patient. Does nursing care vary? If it does, what is the variable, the diagnosis or the patient with the diagnosis? If the patient is the variable then comprehensive nursing care must be "of wide mental grasp" — must be, because it is possible to teach technical skills to those who do not have wide mental grasp. It is also possible that these tasks will be performed correctly from a technical standpoint without much concern for the patient. Comprehension is understanding and this requires use of the intellect. The intelligent nurse understands the technical procedures, what they are, why they are used, what they may be expected to accomplish. The intelligent nurse who gives comprehensive nursing care adds another variable to her performance, the individual patient. The variable exists whether it is considered or not because nursing is a *service to people,* but not to people collectively.

The following comments were made about medical practice:

> In the hospital the patient is not seen in his natural environment and many procedures demand attention, so that few opportunities and little time are available for the serious consideration of the individual and of the personal problems that are contributory to his illness. His *disease* (objective) is studied with great care, but his *illness* (subjective) may be neglected.
>
> In their devotion to science, leaders of medicine have had little time or energy for the consideration of the patient as a person, as a unit in a complex society, and as an organism subjected to many strains and stresses from his environment.**

Where does nursing of the hospitalized patient stand in relation to these remarks?

Each study includes a section called social history. Inclusion of it infers that the nurse recognizes that the patient is a social being, but how is this knowledge used to care for the patient? Do we read in the studies that the nurse behaved in a certain way because the patient behaved in a certain way; that she took cues from the patient and geared her care to him?

The sum total of what the patient is — the whole patient — seeks nursing. The nurse too, brings her entire self to the patient. There is a difference, though. She has been prepared for her role as nurse, he has not been prepared for his as patient. She is

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* Johnson, Dorothy E., "A Philosophy of Nursing," *Nursing Outlook,* Vol. 7, pp. 198-200, April, 1959.

** Robinson, G. Canby, *The Patient as a Person.* New York: The Commonwealth Fund, 1939, pp. 4-8.

reasonably secure in her knowledge of how to nurse, he is insecure as a result of his illness and what it means socially, economically, emotionally. She chose to be a nurse, she likes her role, he does not. How the patient copes with this situation will depend on what he brings to it and what he finds in it. He brings his fears, hopes, prejudices, stereotypes and a host of experiences that have molded him into the individual the nurse encounters. His ability to adjust to his optimum will depend to a large extent on what he finds in the hospital environment.

How does the nurse function? Is her role therapeutic? When she says she "reassured the patient" what does she mean? How does she know? Reassurance is an emotional response which can be experienced only by the patient. It is not something *I* can give to *you*. I can, as the nurse, behave in such a way as to contribute to your feeling of well-being, to your sense of security, to diminishing your fears. If we accept the concept that illness is accompanied by fear, anxiety, insecurity, then is it not part of the role of the nurse to function so that there will be a marked reduction of tension and anxiety?

Nursing takes its cues from patients. Theoretical knowledge in the social sciences acts as a background for the development of skills in interpersonal relationships that are an essential part of comprehensive nursing.

Studies have shown that nearly half of the students go into nursing from an innate interest in helping people. This is fertile ground. The high school graduate has developed some skill in understanding people, some insight into behavior, even though her knowledge is restricted to relatives and close friends. The beginning student likes people, wants to help people. What happens in the next three years that causes the beginner to change her orientation from one that had a 95 per cent interest in people and a five per cent interest in medical science, to almost a complete reversal?

Until such time as the studies describe nursing care in terms of the nurse's activities in relation to the patient and the patient's reactions to these activities, and how the nurse might have nursed the patient differently as a result of the increased understanding gained from her association with him, nursing care studies will continue to be, what they are so often called — simply, *case* studies. They will continue to be disease-centered and task-centered, rather than a true picture of comprehensive nursing care.

P. E. P.

MEMO FROM AUSTRALIA

The following excerpt comes from an Australian letter:

"Please don't expect too hot weather in April as the evenings are always chilly — in spite of Australia being advertised as "sunny" it rains and gets pretty cold, too. However, I can predict many fair days for you as the autumn is the nicest time of the year here. Do please bring sweaters, a couple of warmer dresses and a top coat. You might even be happy to have your flannelette pyjamas, as the hotel accommodations leave much to be desired.

I feel certain you will like Melbourne and its quiet dignity. The gardens will be at their best and you will find your fellow Australian nurses to be kind to you. They will treat you royally."

The new leaflet entitled "Facts about Congestive Heart Failure" may be found useful in teaching patients about cardiac insufficiency. The format of the leaflet is a series of questions and answers in laymen's language. Copies are available from the American Heart Association, 44 East 23rd Street, New York 10, N.Y.

* * *

Just about the time you think you can make both ends meet, somebody moves the ends.

What is Real Nursing?

Role Confusion and Conflict in Nursing

KENNETH D. BENNE PH.D., *and* WARREN BENNIS, PH.D.

This article is based on a talk given to the Forum on Newer Trends in Nursing at Boston University and incorporates findings from a research study on the role of the nurse in the outpatient department. The study was conducted by the Boston University Human Relations Center.

CONFUSION AND CONFLICT about the role of the professional nurse reaches peaks at several sensitive points. Against the backdrop of the analysis of some of these points, we want here to examine more closely three of the principal areas of tension. The first is that the nurse is commonly frustrated by the difference between her image of "real" nursing and the functions she must assume in actual work situations. Second, the nurse-doctor relationship is often a tension area. And, third, promotion for the nurse all too frequently means conflict between her desire for higher status and her psychological need to give bedside care.

The Blurred Self-Image

A nurse's self-image that puts bedside care of patients at the heart of the legitimate functions of nursing appears in many conversations and interviews we have held with nurses. Other functions may be expected of nurses, and advancement in status and pay often requires performance of other functions. But bedside care is still — to many nurses — "real" nursing.

We suspect that this self-image of "real" nursing gets established in a number of ways. The non-nursing public probably has an image of "the nurse" always at the bedside of the patient. This may be an untutored image, but it is nevertheless a reality. When persons choose nursing as a career, they choose at least partly on the basis of this public image.

They bring this image of "real" nursing with them to school and often the schools don't dislodge it, even where they try to do so. And we suspect this image of "real" nursing is reinforced by continuing contact with patients. Patients and their families sometimes complain in hospitals if aides or practical nurses or attendants care for them. *Nurses* should care for them. And patients' families often reinforce this complaint. Doctors, too, frequently judge nurses in terms of a similar image.

Our research indicates that the nurse is actually required to perform five major functions.

The first we can call the technical functions of nursing procedures. Second, she acts as administrator in ordering supplies and keeping records. Third, she is an organizer, who must work in and maintain a complex organization replete with problems of hierarchy, communication, and control; she is supervised, and she supervises. Fourth, she is a teacher and trainer of other hospital personnel and of patients. Fifth, and finally, the nurse involves herself in the informal social fabric of the hospital, clinic, or agency — interacting with colleagues with whom she shares intimacies, small talk, gossip, and social intercourse. Perhaps only the first of these functions fits the picture of the bedside

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Dr. Benne is the Theodore W. Berenson Professor of Human Relations and the director of the Human Relations Center of Boston University. He is a cofounder of the National Training Laboratory in Group Development at Bethel, Maine. Dr. Bennis is assistant professor in the Department of Psychology and senior research associate in the Human Relations Center, Boston University. He is, at present, senior investigator, U.S. Public Health Service, on the project discussed in this article.

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nurse offering tender, loving care to a patient.

When the nurse with an image of "real" nursing as being bedside care of patients approaches the actual job, she is in for a severe jolt. She was not prepared — psychologically or technically — for the myriad of other duties that she has to perform, and she is not really sure she likes it this way. In short, there is a sharp discontinuity between her self-image of nursing and the actualities of work life.

And, where the nurse isn't prepared for the actualities of the job, she feels frustrated in that she isn't living up to proper nursing standards. One nurse in an orthopedic clinic, for example, spent a good deal of time just distributing foot-pads. She told us that she felt more like a shoe clerk than a nurse. We discovered, too, that many nurses felt frustrated because, in their opinion they were not actually performing skills for which they were trained and which they expected to carry out. Because this phenomenon was so visible and regularly observed, we coined a concept which we felt aptly describes the condition, "role deprivation."

Let us look at this source of tension from another angle. One psychological characteristic of acutely ill patients is their regression to a state of rather complete dependence. It is quite possible that nursing has tended to attract people who like to respond to dependency in others. Insofar as this is true, the chief psychic rewards of many persons attracted to nursing come from taking care of dependent patients. It is hard for some nurses to get as much satisfaction from dealing with convalescent patients who have become less dependent, or from teaching patients to become more independent, even when the realities of the treatment situation require this shift in the nurse-patient relationship.

Our OPD study shows that the nurse who responds overeagerly to dependency has a particularly difficult situation in the OPD, where the patients are ambulatory. Unlike the ward patient, who is more completely under the control of the hospital staff, the ambulatory patient has a good deal of control over whether or not he will follow the nurse's advice. She has to depend on her persuasive ability to influence the patient rather than on the more direct control which her colleague in the ward may have.

Now, let us look again at the problem of redefining "real" nursing in this setting of nurse-patient relationships. The nurse is called upon to train aides and to organize and coordinate their work. Often not dependent at all, they are very, very "ambulatory." When a nurse who likes to respond to dependency, and who at some level of consciousness may have selected her vocation because of this, has to shift into functions which require other relationships, tension and resistance are bound to result, because many of the nurse's greatest psychic rewards are missing in the new functions. We have heard nurses in rather high administrative positions (talking off the record) who wondered whether they were actually doing "real" nursing at all. We have heard persons in very important positions in schools of nursing express the same doubt. Their separation from the bedside care of patients seemed to account for this sense of unreality in their work.

Whatever the extent of this particular tension within the nursing profession — and certainly much more empirical research into it is needed — evidence indicates that confusions and conflicts over the nature of "real" nursing raise important questions concerning nursing recruitment and education and the development of effective treatment teams in which nurses play a part.

The Nurse-Doctor Conflict

There are, no doubt, conflicts and tensions between the nurse and parts of the treatment team other than the "doctor" part. But few who have talked, under free conditions, with nurses will deny that the nurse-doctor relationship is the one most pregnant with tensions and misunderstandings on both sides. Off-the-record talks with some doctors reinforce this impression, although more research is required on this side of the relationship.

Why is this so? The recent history of the development of nursing as a profession is partly responsible. During the past 25 years, and at an accelerating rate, nursing leadership has

exerted tremendous and admirable efforts to create a nursing "profession" in the full sense of that term. The expansion of university-connected schools of nursing, the multiplication of graduate programs of professional education for nurses, and the formation and support of nursing research are all evidences of this determined effort toward professional upgrading.

One fascinating side of this history of accelerating professionalization deserves intensive study in this context of conflict and misunderstanding between nurses and doctors. Nurses, in rooting their profession in university and academic life, have tended to form alliances with the social and behavioral sciences much more fully than the medical profession generally has done. The firm alliances of the medical profession within academic life are still with the physical and biological sciences.

One must look to the newer "upstart" branches of medical specialization — psychiatry, public health, and hospital administration — to find infiltration by the social and behavioral sciences to anywhere near the extent that prevails in professional nursing. Perhaps some of the conflicts of academic life, between the social and behavioral scientists, on the one hand, and biological and physical scientists, on the other, have been translated into the professional nurse-doctor relationship.

Many doctors seem to be unaware of this move of nursing toward professionalization or, if aware of it, to ignore it in their working relationships with nurses. Certainly, one earmark of a professional person is the possession of areas for the exercise of independent judgment within his work life. The function of professional education is to prepare the person to exercise such required judgment. But many doctors still expect nurses to behave only as obedient extensions of their own professional judgment. The fiction seems to be that the nurse is the doctor's helper only. Yet, in fact, nurses must frequently make independent judgments which affect the treatment process.

So, on the one hand, we find schools of nursing and professional nursing associations reinforcing the nurse's self-image of an autonomous, professional person, sharing with substantial equality in appropriate judgments about treatment processes. On the other hand, we find doctors, perhaps reinforced by neglect of the study of nursing — if not by contrary indoctrination — within their professional education, ignoring or controverting this self-image of professional person and colleague which many nurses hold. The results are bound to be inner tension within nurses and various off-target ways of channeling their feelings of resentment, if not open conflict.

We have heard nurses say that doctors in different specialties vary in their willingness to enter into a professional colleague-relationship with nurses. The least reconstructed doctors in this respect seem to be surgeons, and the more reconstructed ones psychiatrists and public health physicians. Whether these differences are significant by research standards, and how far the realities of the differing treatment situations validate whatever differences exist, only further research will reveal. Meanwhile, the role conflicts they generate in nurses are social and psychological facts.

Nowhere, probably, is the relationship between the physician and the nurse more prominent than in the OPD. One of the chief complaints among OPD nurses is the failure of the doctor to be at the clinic at the appointed time. Everything, except the unrelenting flow of patients crowding the clinic, then comes to a standstill until the doctor arrives. And meanwhile, the nurse has to maintain the organization and its public relations!

Another facet of the nurse-doctor relationship is that, in many OPD's, the nurses are experienced workers who have held one clinic position over several years. The doctors, on the other hand, particularly those on rotation, are not at all used to the clinic. This creates an unusual situation. Although the doctor has a senior position and is supposed to give the orders, he knows less than his nurse associate who is expected to take orders.

In some cases, the nurse has the most delicate job of attempting to maintain the doctor's status. Gently telling him what to do, she must, at the same time, appear to obey his orders

In extreme cases, this can develop into an unpleasant relationship where the nurse "Doctors" or "Sirs" the doctor, while visibly showing up his lack of knowledge of the clinic as she gives him the information he needs. Undoubtedly, this same sort of drama is played out — even more theatrically — each time experienced nurses deal with interns or inexperienced residents in the hospital situation.

Nurse-Supervisor Conflict

We have already mentioned the feelings of alienation and deprivation which some nurses experience when their job assignments fail to include duties which for them represent ideally "real" nursing. There seems to be further ambivalence in nurses, especially in those who have been promoted or who are threatened with promotion, about the functions assigned to them in their work. Nurses seem often to be saying — both at the same time — "They expect too much from me as a nurse," and, "They don't expect enough from me as a nurse." How can this be explained?

To investigate the functions of the OPD nurse, we asked her to rank the amount of time she spends on each of 12 categories of duties. These categories were: Clinic administration, administrative duties, teaching and orientation of personnel, teaching of patients, supervision, social activity, learning, smoothing out frictions between departments, smoothing out frictions within departments, physical nursing care, referrals and referring, and others. We also asked the supervisor of each OPD to rank the 12 categories of functions in the order in which she preferred her nurses to spend their time. When we compared the rankings of the two groups, we were somewhat startled by the lack of agreement.

In one hospital, for example, there was practically a perfect negative correlation. Some examples of the discrepancies may be illuminating. When the nurses ranked the various duties in the order of time actually spent on each, they ranked administrative duties third or fourth. Supervisors, on the other hand, ranked administrative duties eighth or ninth in order of importance. Even though the nurses spend more time at administration than their supervisors like, the reality of the job appears to augment the administrative functions of the nurse. Thus, her feeling that she is doing too much administration and too little "real" nursing is reinforced.

Our data highlight one more aspect of this role-deprivation theme. A number of studies show that nurses avoid administrative responsibility. Argyris discovered for example, in case studies in a cancer hospital, that only 24 percent of the nursing supervisors, 9 percent of the head nurses, and no staff nurses at all, desired to be supervisors.[1]

Yet it appears that if a nurse wants to advance within the hospital setting, she will have to take on more and more administrative functions. At the same time, she feels painfully unprepared for this responsibility. Furthermore, she does not think this is "real" nursing. There is as yet no plan within the hospital that will allow the nurse to continue to use and improve her nursing skills and still be promoted after she reaches the head nurse stage. Thus, we have pressures by administration to promote the efficient nurse into a job which she doesn't desire and for which she is frequently inadequately trained.

Two Roads to Better Promotions

There is now no way to promote a nurse into a new role that really incorporates her professional skills. This dilemma of having to choose between practicing the skills of the profession and enjoying the advantages of promotion is not peculiar to nursing. Various classes of professional personnel in research and industry are facing this issue, too. Two complementary approaches to its amelioration have most often been used.

The first approach is to create a "skill hierarchy," an organizational ladder with the same range in status and rewards that the administrative hierarchy possesses, in which one can be promoted without having to become an administrator. The Bell and General Electric Laboratories have created such dual hierarchies of promotion. To be promoted, a research scientist does not have to become an administrator. Rather, his pay and his status increase when he is appointed to an appropriate

rank such as "Distinguished Scientist." What would be wrong with exploring a title of "Distinguished Nurse" or some such within nursing?

The other approach is to find nurses who desire administrative work — and there are some — and to equip them with the necessary skills. We met several such persons in our sample of hospitals; and the administrative acumen of these administrators, combined with their nursing sophistication, makes for highly effective administration.

Patterns of Adjustment to Conflict

Many nurses with whom we have talked are aware of some of these conflicts and confusions. And, too, they have talked to us about how they deal with them. We would like to comment briefly on some of these ways of adjustment.

But first, one historical observation is in order. Many of these role conflicts and confusions are related to continuing and accelerated change in the health field. Concepts of restoring health and preventing disease have changed markedly in the last generation. And, with changing concepts, technologies and methods of organization have changed, too. Wherever research and its application are extensive, change has become the law of contemporary organizational life.

And, where changes in ways of carrying out functions occur, role expectations and definitions are bound to change, too. Where change is uneven — and it seldom is even — conflicts and confusions in professional roles are bound to occur. Actually, the only way growth in a profession or within professionals takes place is through the creative resolution of conflicts of this sort.

Typically, growth occurs only when the fact of confusion and conflict is accepted, in some degree, by those caught in it. The denial of conflict or of its factual roots usually leads to adjustments quite other than those of growth, either for the profession or for individual members of it. Let's look first at three patterns of adjustment to conflict and confusion which involve denial both of the fact and of the determinants.

First, to adjust to or to reduce conflict, the nurse may develop low motivation for her work. This is a protective mechanism. If the job involves conflicting demands which cannot be satisfied without changes in herself and in the situation, the nurse may lose interest in the job or forsake the effort to find satisfaction in it. Either action will reduce the influence of these conflicting demands upon her. Insofar as she can make the job less important in her life, the conflict — while still present — may not tear her apart so much. And, in effect, she may say, "I'll go through the motions on the job, but I'll find my fun elsewhere."

Second, some nurses have told us that they rationalize away part of the conflicting demands. For example, if there is a marked conflict between the demands of the institution the nurse is working in and the expectations of the nurse's school and professional associations, she may call the schools of nursing and the professional associations, "impractical," "theoretical," and "disoriented to the realities of the nursing job." While this may help her hold her job, it shuts off influences that might facilitate professional growth.

Third, the nurse may formally or informally organize with others to resist the demands of the institution where she works, whether these demands are reasonable or not. This is usually a kind of informal organization of resistance to institutional demands — passive "misunderstanding," a slowdown of efforts, and watering down of orders in the execution of them. In these indirect ways, nurses hit back at the persons who make demands that they feel conflict with what is proper, just, or progressive.

None of these ways of handling conflicts is, we suspect, conducive to growth of the profession or the professional. The healthiest way in which nurses handle their conflicts is, first of all, to accept them and to locate their sources in the conflicting expectations of the persons concerned, including themselves. This may involve considerable investment of time in group situations with other nurses who are also seeking clarification of their roles and situations.

Eventually, the nurses must seek to communicate openly about the conflicts with the various persons involved.

It is not enough to establish regular, formal, highly edited, surface communication between nurses and doctors, or between nurses at different organizational levels. The communication must become free and probing enough to bring into the open, actual feelings and actually conflicting expectations. Commitments to some compromise or synthesis can be reached only if the fact of a problem is accepted and its nature explored by all concerned.

No doubt, some of these conflicts cannot be resolved through more adequate communication and decision within any one clinic, hospital, or other treatment agency. Some will require decisions in and between nursing and medical schools. Some will require decisions in and between nursing and medical professional associations and, no doubt, among these and associations in other helping professions as well. But it is probably true that, in such decisions — just as in those taken in clinics and hospitals — healthy and effective decisions will require the achievement of deep-cutting communication. Such communication must generate open acceptance of the conflicts and common commitment to diagnose and treat these together. Meanwhile, much more empirical research into the organizational and role behavior of nurses and other professional individuals in the health field is required.

The Nurses' Grail – Good Nursing

HAZEL KEELER, M.A.

What is good nursing? Many people have tried to frame answers to that question.

Just Plain Nursing

I HAVE BEEN THINKING about the phrase "Just plain nursing." It is the style now to define your terms. As a result I have discovered that there are many meanings for the word "plain." Some of them are:

> Smooth, even, simple, unadorned, without beauty, homely, unlearned, without refinement, mere, without difficulties or intricacies, unsophisticated, evident to the understanding, clear, not highly seasoned.

I have never come across a word with quite so many different and apparently legitimate meanings. Some I rejected as not very descriptive of the word *plain* when it is used to qualify nursing. Others I liked — smooth, even, evident to the understanding, and without difficulties!

After establishing some of the meanings of this interesting partner to the word nursing, I leafed through a few of the recent professional journals to see if there were any articles similarly titled. I did not find any specifically so designed, but I was struck by the number of articles written with the evident intent of probing deeply into the heart of nursing. Some of the titles I found were:

> Wanted: Good Nursing
> The Scope of Professional Nursing
> Toward Professional Competence
> What is Good Nursing Care?
> Has Nursing Changed?
> Florence Nightingale's Message for Today
> Some Problems in Modern Nursing
> Whither We are Tending

That nearly every issue of our various journals carries such articles seems to point to an almost universal desire to look searchingly at nursing; to reaffirm our belief in the worth of nursing; to pinpoint just what nursing is and perhaps, more than anything

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Miss Keeler, who is director of the school of nursing of the University of Saskatchewan, is chairman of the National Committee on Nursing Education. This address was delivered at an institute on "Just plain nursing" sponsored by the Registered Nurses' Association of British Columbia.

else, to reassure ourselves that it is what it should be. The clause, *what it should be,* probably expresses where our doubts lie. We so want nursing to be what it should be so deeply — if we could only just be sure *what* it should be!

It is not a sign of weakness to ask ourselves "What is nursing?" Nor is it a sign of weakness to search for better ways to help patients; for better ways to use our nurses effectively; for better ways to prepare nurses. Long ago Florence Nightingale said:

> May a better way be opened! May the methods by which every infant, every human being, will have the best chance of health, the methods by which every sick person will have the best chance of recovery, be learned and practised!

A Modern Grail

What we have set for ourselves is a kind of modern Holy Grail. In doing this, we are simply following the pattern used once upon a time by the knights in the court of King Arthur. Do you remember when the Connecticut Yankee got himself into that Court? He found that all of the knights were taking an occasional flyer at the Holy Grail — in fact, whole expeditions went out grailing. Now, the knights didn't know where to look for the Grail and actually didn't expect to find it and probably wouldn't have known what to do with it if they *had* found it. However, the point was that they kept hunting for it and, in doing so, they slew dragons and rescued fair maidens and eventually brought the art of chivalry to a very highly developed state.

If we can just emulate the knights and keep searching for *our* Grail — good nursing — we may find that along the way we have removed many difficulties; found new objectives; increased our understanding and developed the art and skills of nursing into a still more potent social force for the betterment of mankind even if we never reach the ultimate. As with the knights, the real value lies in the search. Again quoting Miss Nightingale, "No system can endure that does not march." She went on to say, "Are we walking to the future or to the past? Are we progressing or stereotyping?"

The Core of Nursing

There is much that is bad in our past but we also have a wise old past. It is from the wise part of our past that we derive the true core of nursing that has endured since the days of the primitive mother. The true core is the ministrations and comfort measures, the supportive role; the ability to empathize (a fancy name for something that many nurses have always been able to do!); and the tender loving care that was given empirically in distant times and then with increasing understanding as knowledge derived from all of the various sciences gradually became available to us.

Until about 25 years ago this true core of nursing constituted, in large measure, the whole of nursing. Some of the bad, not necessarily all of our own making, lingered on to very recent times. Such things as crowding the public wards with the indigents (horrible word! We seldom use it here nowadays!), waking patients at the crack of dawn; keeping patients in bed until they became so weak they had to go home to recover; giving out old clothes in the name of social service; limiting our care strictly to the period of time between admission and discharge; accepting the hospital as a place where patients came to die; designating patients by the room or bed they occupied or by the disease they had; identifying babies by a number; routinizing our nursing activties for all patients; paying great attention to the state of the linen cupboard and no attention at all to the personalities of the patients — all these should belong to the dead past. But, through all this, our true core of nursing remained a mitigating influence offsetting these less laudable practices.

However, although the core of nursing has remained, it has tended to become obscured by a multitude of new activities thrust into nursing by forces beyond our control. In the early 30's a fresh breeze began to sweep over the health field. I remember the year 1935 very well. That was the year when the first of the sulpha drugs came into use, to be followed in quick succession by a host of other so-called miracle drugs. It was in 1935 that I heard the phrase "the patient as a person" and I marvelled at the rightness of the implica-

tion. It was in 1935 that Isabel Maitland Stewart in New York was asking the question, "What philosophy shall we accept for our new curriculum?" In 1935 Marion Lindeburgh, working at McGill University, was putting the finishing touches to our *Proposed Curriculum for Canadian Schools of Nursing*. 1935 was a great year, as worthy of being remembered as 1820, the birth date of Florence Nightingale.

Then, a ferment in the scientific field began which, in spite of war and rumors of war, depressions and recessions, gathered such momentum that it has continued with increasing speed to the present time. My prediction is that it will continue to increase until it literally taxes the wildest imagination of the science fictionists to guess at what the next few decades will bring to the peoples of the earth.

The result of this upsurge of scientific investigation has had its influence on all aspects of human life; an influence that ranges from better and faster ways of killing us all, individually and en masse, to the most refined ways of keeping us alive and healthy; from Kitty Hawk to space travel and the intriguing thought that by the year 2000 we may have nursing stations on the moon!

Changing Face of Nursing

You are familiar with the changes that science has brought to the diagnostic and curative aspects of patient care. Improved methods of diagnosis and treatment; the development of new types of operative procedures; the staggering volume of drugs that are placed on the market each year; these have all been utilized by our medical colleagues to bring about the successful control of many diseases and conditions that, a few years ago, would have been impossible to treat. The repercussions from these very desirable changes in medical practice have had a tremendous impact upon nursing and the nursing profession.

The social force that is medical science is not the only force that is having the effect of changing the face of nursing. There are others. The dream of hospital care available to all is rapidly becoming a reality with the introduction of the national hospital insurance program. Christina Rossetti must have been thinking prophetically about Canada as heaven when she wrote these lines nearly one hundred years ago:

> Will there be beds for me and all who seek?
> Yea, beds for all who come.

I do not think for one minute that we have *begun* to feel the influence of the national hospital program. Our hospitals are operating at capacity or over already and the demand *now* for the services of nurses is greater than can be comfortably met by the profession.

Another social force, less dramatic perhaps but just as important in its influence on nurses, their preparation and their work, is that which stems from the social sciences. At no time in history have we known so much about people as individuals, and about people in their multitudinous types of social groups. Literature is simply teeming with articles and books that help us to understand ourselves and others better. We know, or *think* we know, how people learn, how they act and react to different situations that involve fear, stress, security, insecurity, loneliness, rejection and aging. We know about our status seeking, our predilection for "togetherness," and our desire for conformity. We know about the "storm warnings" of juvenile delinquency and of alcoholism. We are aware of our too ready acceptance of mediocrity.

We realize, too, that although we have at our disposal much useful information about people as people, the amount we *don't* know still far exceeds what we *do* know. At the same time good use is being made of our present knowledge. The growing list of new words in our vocabulary testifies to this: Personnel management, phychological testing, interaction, communication skills, human relations. A by-product of our concern for people is the ever-shortening work week, and the shorter work day. What nurse of 25 years ago would have thought that the time would ever come when the five-day week and the eight-hour day would be the accepted thing? I am sure that if any nurse had even given it a thought, she would have said that it couldn't be done because how would she be able to keep track of her patients.

What of the Future?

All of these changes are having a terrific impact upon nursing and the end is not yet in sight. We have already incorporated into nursing many procedures that, not so long ago, were a part of medical practice. This has put a strain on our own resources and forced us to delegate many of our bedside nursing functions to others. In the August 27, 1960 issue of *MacLean's* magazine, I read this interesting paragraph written by a doctor:

> Much of the time of any busy doctor is eaten up by clerical and routine drudgery far below the level of his true medical competence. The answer lies in more medical education — not merely of doctors, but of the nurses and technicians who should be shouldering the less highly skilled work.

We have been adding to our technical duties and responsibilities for a good many years now. Nursing is not defined legally in Canada. But even if our functions *were* clearly delineated by nurse practice acts, I am sure that as more medical procedures became routinized and relatively safe, they would simply be bootlegged into our list of duties without too much difficulty for the medical profession and without too much protest on our part. Is this related in any way to status seeking on the part of nurses? Will it result in Florence Nightingale's lamp becoming so heavy that we will have to let it go? In answer to the first question, I think the answer is no. I worry a bit about the answer to the second. Nurses, as I know them, are simply and sincerely trying to cope with the multiplicity of tasks that are to be done nowadays in meeting the sickness and health needs of people.

I am sometimes disturbed when I read the grandiose pronouncements made by nurses about the aims of nursing. Here is one:

> Nursing meets the total needs of each patient as an individual — his mental, physical, spiritual and social needs.

My imagination is lively enough to accept the fact that the hearts of nurses may be big enough for this concept. My imagination breaks down when it comes to thinking about the nurse's head being large enough to hold so much, or the nurse's hands — well the allotment is only two per nurse, however skilled these hands may become!

Good Nursing

This brings us right back to our Grail. What do we mean by good nursing? First of all, in its broad frame, nursing has not changed very much from what it has always been. I see nurses going about their work on the wards of hospitals and in patients' homes just as they always have. The difference is that many of the things they do are much more complicated, involve more skill than previously and some are shared with nursing assistants, orderlies and aides.

Sharing some of our responsibilities with other workers has increased the need for us to have greater knowledge and skill since we must be able to teach and supervise them. It cannot be a case of the blind leading the blind. The person who assumes responsibility for directing others must know a good deal more than what she actually shares with her fellow-worker; otherwise she is not comfortable in the process and cannot be so effective. However sharing nursing functions with other workers and assuming responsibility for directing them does not change the meaning of nursing and does not undermine its true core.

Nursing, as I see it, should provide the patient with a sense of being cared about, understood and supported throughout a period of need. Nursing involves carrying out the therapeutic regime prescribed by the doctor. Nursing fortifies the care given by other departments, complements the activities of the other health professions and thereby is in a key relationship. Nursing can identify patient needs not readily discernible to other health workers because of the continuity with which it serves the patient in hospital, at home, at school, or in business, if necessary. Nursing teaches the patient and his family what is necessary for self-care and what community resources are available.

These facets of nursing can all be spelled out in more meaningful detail and many others can be added. One that cannot be spelled out so easily has to do with what our psychiatric friends call the "therapeutic milieu" for the patient. "Therapeutic milieu" may

sound a bit jargonish and I have been trying to think of a better term for what it stands for. It is much more subtle than well-made beds, perfectly executed procedures, proper diets, and careful discharge planning and instruction. It involves the emotional climate surrounding the patient. This, in turn, is related to good interpersonal relations, insightful observation, good communications, and flexible administrative skills. It involves the nurse accepting herself and being accepted and respected by all whose duties bring them to the patient's bedside.

Some nurses seem instinctively to be able to create just the right atmosphere in which patients thrive. Everyone, from the cleaning woman with her mop to the most senior member of the health team, reacts to it and puts forth that extra bit. What is this something, that some nurses have? I asked a few of my colleagues if they knew what it was. They thought it included the wit to use all of the elements that I have mentioned, together with the spice of femininity and old-fashioned charm. If they are right then we must do what we can to encourage the development of these important catalytic qualities.

The process involved in thinking about nursing, in identifying and clarifying its various functions, in striving to improve the quality of nursing, and to discover what constitutes goodness in nursing — this process is the search for the Grail of our profession.

A NEED FOR CHANGE

GUILLAUME G. C. RUYS, R.N.

This emphasizes once again that the patient is a person, not a case.

PEOPLE CONCERNED WITH nursing today, are beginning to realize more keenly the need for a change in its approach. It is felt that this should be a change in the *quality* of nursing care, rather than the *quantity*.

We have always striven for the best in nursing care, such as improved aseptic conditions, good preoperative and postoperative care, a healthy environment. This of course, is all very important and necessary. However we should be increasingly aware of altered factors in our society that require a corresponding alteration in our professional outlook.

Illness and Emotions

One of the principles of good nursing care, is the realization of the mental and emotional needs of our patients. In order to meet these needs it is essential that the professional nurse should have a working knowledge and understanding of behavioristic patterns and their implications in relation to illness. The accent in modern nursing should be on *the patient as a person*, rather than on the patient as a case in the more technical sense.

Every ill person may exhibit certain personality changes, which may be the direct result of his illness. He may therefore behave or act in a way that is unnatural. On the other hand, his illness may be caused, either directly or indirectly, by stress. Considerable research is presently going on in relation to stress and its effects. The importance of stress factors as related to physical illness is becoming much more generally appreciated. From that point of view, we can readily see why there is a need for some modification in our patterns of nursing care.

We are all subject to anxiety and tension at one time or another, the severity depending upon the circumstances. We are strongly influenced by environmental conditions and per-

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Acknowledgement is made of the wise counsel given by Miss F. Roach, dean of the School of Nursing of Assumption University, in the preparation of this material.

sonal make-up. Well-adjusted people, brought up in a favorable environment, are usually much more able to cope with their emotional problems than those who have been subject to less favorable situations. Some of the latter group will often remain emotionally unstable. They will need a great deal of understanding and encouragement from those about them.

Social and Cultural Aspects

The population of Canada is presently comprised of individuals from a wide variety of national backgrounds. Each one has brought his own customs and mores. These are frequently very different from the ones with which we are familiar. These differences tend to puzzle and confuse us. The professional nurse needs insight into and understanding of the sociological aspects of nursing.

We should keep in mind that many new Canadians have been through very difficult times in their own countries, due to war and post-war conditions. Sometimes this has caused considerable mental trauma. Their arrival in this country means that they have to make yet another adjustment to our customs. Usually they have to overcome a language barrier in addition. All of this can be very upsetting. If on top of all this, our new Canadian has to be hospitalized we do not need to be very imaginative to understand his attitudes and reactions. It is under those circumstances that we may make our first contacts.

Interpersonal Relationships

To carry out a satisfactory and efficient nursing program there must be a good system of communications and pleasant relationships between the various departments.

The professional nurse must remember that much of the bedside care is being given by non-professional personnel, such as nursing aides and medical orderlies. Their attitude toward the care of the patient will often determine the quality of nursing care given and consequently the speed with which the patient recovers.

A doctor once said, during a television broadcast,

> In this world today, there are fewer people who are unhappy because they are ill, than there are people who are ill because they are unhappy.

We may well ask ourselves then, what are we doing to make our patients happy?

As we established before, non-professional staff are giving a large proportion of the nursing care under the supervision of the registered nurse. However if we, as professional staff, lack understanding of human behavior, how can we teach auxiliary staff these principles?

We must through our own attitudes create a congenial atmosphere. We must try to free ourselves from prejudices and petty misunderstandings. If we can develop a happy atmosphere on our wards then we can expect the wheels of nursing to turn smoothly and the patient will benefit proportionately. When tension and friction exist, nursing service can not operate effectively and efficiently. The patient will ultimately be the victim of inefficient nursing care.

Our main motive should be the well-being of the patient. No matter how skilled we are if we are not motivated to give service, our efforts will be less than fruitful. A purely selfish attitude in nursing is usually a mark of immaturity.

The change in nursing would consist in fostering understanding of the socio-psychological aspects basic to a knowledge of human behavior, and in creating a congenial environment that will promote the speediest recovery of the patient and make his stay in our hospitals as pleasant and comfortable as possible.

Learning without thought, is a snare; thought, without learning, is a danger. When you know a thing, maintain that you know it; and when you do not, acknowledge your ignorance. This is characteristic of true knowledge. — CONFUCIUS

Why are dates packaged in amber-colored cellophane? Cellophane must be treated so it does not breathe in order that the moisture from the dates will stay in them. This "treatment" causes the paper to turn amber in color. — *CAC Bulletin*, October, 1960

A BACKWARD GLANCE

MICHAEL JOSEPH TROY, C.S.Sp., Ph.D.

In these days of increasing emphasis on technological developments in hospital work, it is important to consider whether such progress will of itself completely satisfy that most exacting of groups — the sick folk of our hospitals. The present article suggests that if equal attention is not paid to the still deeper human and spiritual aspects of physical suffering, all such blueprints are doomed to disappoint their architects — and prove failures in the eyes of those for whom they have been designed.

EVEN THE MOST ARDENT ADMIRER of the good old days must admit that in hospital accommodation, equipment and medical skill there has been an unprecedented advance in the present century. The blueprints of future model hospitals portend still finer achievements to come, so much so, that one is easily led to think that there is nothing to be gained by consideration of older traditions now already to a large extent outmoded. This would be a serious mistake, especially in view of the imminent danger that such future schemes may be unduly influenced by present-day trends of thought in favor of the Welfare State.

The Personal Approach

However inhuman by modern standards many of the nursing methods practised in the past, there was in them this redeeming feature — there was something very human in the attitudes of nurse to patient. The voluntary and often gratuitous nature of these earlier systems emphasized this factor. It was a heritage of the old spirit of medieval nursing where the monastery *hospitalium* was thrown open to traveller and sick alike — gratuitously, for the love of Christ. This spirit was early lost in public concern for travellers when, after the break-up of Christendom, laicism and commercialism found their way into hotel and hostel organization. The old Christian idealism in the care of the sick, however, still clings to our hospitals, but unless serious effort is made to revitalize it, in another generation or so, there will be as little of this idealism in a hospital nurse as there is today in a hotel waitress. The impersonal and institutional spirit of all state and commercial enterprises will almost inevitably lead to a slackening of the close personal link that once joined nurse and patient. This de-Christianization and dehumanization of hospitals has already made disconcerting progress in many countries. It is vain to hope that our own will come entirely unscathed from such ideological struggles.

Clear thinking and concerted action on the part of all within the nursing profession will become more and more imperative in the years ahead. It is hoped that the nurses and doctors themselves, will be in the van of this important movement.

The Call for Sympathy

While, therefore, the nursing profession must keep abreast of all the latest and best in technological practice, it should be careful not to lose thereby anything of value in its traditions. It would be a pity if we should do in medicine as we have done in other important departments — fail to bring technological discoveries into line with higher human and spiritual values. Improvement in hospital and nursing standards will only be fully effective if due importance be given to personal sympathy with and interest in our patient, for these will continue to distinguish the really good nurse from the merely efficient. The cure will not always be in the nurse's power, even with technological improvements, but sympathy should be. In fact, the more remote the cure, the

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more imperative the sympathy.

The Essence of Sympathy

What is sympathy, then? It is, curiously enough, a word with a medical background signifying those qualities of mind and heart that enable a person to readily suffer (Greek — *pathein*) in union with *(syn)* a suffering patient. Its importance may be judged by the fact that merely to sympathize is already to considerably relieve the sufferer. It is to share his trouble — to make it one's own. It is to treat a patient as another self, not as a mere casualty — a *case* — somebody by chance entrusted to one's professional care. If, therefore, a nurse by her womanly spirit of ready sympathy and pity fails to enter into her patients' individual sufferings, her newer methods will avail her little. She will never win her patients' confidence. To do so, she must become all things to all, even the most unlovable and disgruntled. Patients overlook many shortcomings in a nurse — but they never forgive lack of feeling or calculated harshness.

A moment's reflection will show that such is almost inevitable, since patients ordinarily come to hospital in great pain, preoccupied about many things, and lonely — in a word, very much at a loss in the strange atmosphere of hospital life. This is especially true of the very young and the very old. The latter have not quite thrown off the idea, fashionable in their own day, that hospitals are only glorified hospices of the dying — so they need to be reassured, consoled and ***nursed***. It is here that the superficial diagnoses will fail. Nurses may rely on the best clinical procedures to diagnose their patient's ailments, and still fail to reach their deeper needs. Being themselves in good health and inured to the institutional life of a hospital, such nurses are very prone to become victims of that unfeelingness which so often characterizes professional people who do not consciously strive to maintain vocational idealism. To do so, in spite of routine, nurses must approach every new patient as they did their first. They must make each one feel that he or she is the object of their personal attention — not merely another of a crowd.

Cultivation of Sympathy

A practical problem at once imposes itself. If the virtue of sympathy is so important, can it be developed or won back where lost? Certainly, but only at the price of perseverance! There is no ready cure for insensibility — any more than for any bodily ailment. It is useful, as well as chastening, in extreme cases of insensibility, to recall that every nurse is obliged by contract to be sympathetic and helpful. That is her job. She is paid to be so, for in present-day hospital schemes, everyone pays for the services received, either directly or through taxation. No one should, therefore, be given the impression that their medical services are being given as a mere favor. The patient has a right to as much value for his money in a hospital as at the local cinema or railroad. The services are different, but his right to them rests on the same principle — contract. Such a principle of *des et do*, it is readily admitted, will never inspire very high standards of devotion, but it will ensure minimum professional etiquette — good bedside manners — that are unfortunately sometimes missing.

Few nurses, however, will be content to make of their nursing a mere job, when it can be something higher, something *vocational*. To achieve this, one must cultivate a genuine love and sympathy for patients; one must sublimate all mercenary considerations. One must strive to do good — to be devoted to the patients — an ideal quite different from that of mere devotion to duty. And in this connection it is good to remember that *patients have feelings as well as diseases*. A harsh voice, especially if it continually nags, can rapidly undo hours of good work. A pleasant smile, a hearty greeting, a word of recognition or gratitude have powers for healing not to be despised. One spoon of honey can be more potent than many vials of vinegar.

Downright hostility in patients should be thawed out by kindness rather than matched with a studious armed neutrality. Even when such treatment fails, one must be merciful, never descend to meanness or vindictive action. Mercy and forgiveness ever remain the supreme test of the really sympathetic, who graciously accept the situation or person they cannot alter.

Such people go so far as to excuse even downright perversity — finding in themselves the root of other people's failures. They are never bitter, even to the malicious, for they know what is in man, especially when unwell! They smile understandingly on the lovable and unlovable like the providence of God which rains on the just and unjust.

None is so insensible that they cannot correct themselves; none so sympathetic that improvement is impossible. All lack of sympathy for others has its roots in selfishness — *too much sympathy for self.*

The Mystical Approach

But such sympathy must go deeper than merely humanitarian considerations if it is to stand up to the shock treatment it is likely to meet in the daily wear and tear of hospital life. The glamor of selfless nursing quickly grows thin unless it finds constant inspiration and strength from higher principles. These it will find only in the mystical approach to nursing what sees its own ministrations in the light of what mysterious identification of suffering humanity with the suffering Man-God. It recalls that what is done to them, are considered as done to Him. All those blood-drenched dressings are so many linen veils of Veronica to wipe His face; every call for drink an echo of His cry "I thirst." A nurse is thus transformed in a new Veronica — a second Cyrenian accompanying Him up the last steep stages to Golgotha. She meets Him on His doleful journey; she stands by His cross; she takes Him down and prepares Him for the tomb! But the sickness is not always unto death. The nurse, like Christ, will sometimes see the lame walk again, the blind see, the lepers cleansed, even the seeming dead revive. This is sympathy *par excellence.*

While a nurse thus thinks of Christ, her work can never remain a mere job, but becomes a glorious vocation. That is way there are still many who make of it a religious vocation. It is basically a work of mercy. That is why there are still many who make of it a religious vocation. It is basically a work of mercy. That is why religious Sisters will always have something to give to the nursing profession. They will be the extreme right wing of those who nurse for higher motives than sterling. It will be a sad day for suffering humanity, if ever this devotion to the sick be forgotten. As great an effort must be made to keep Christ in the hospital, as to keep Him in our schools, our homes and churches. No technological improvement gives meaning — nor ultimate healing — to the sufferings of humanity. It is Christ who shows real meaning to nursing — and raises human sympathy up to the level of Charity Divine.

Looking Forward

Keeping Christ in the hospital then is a much more far-reaching principle than merely providing a modicum of hospital chaplains. It means that Christian principles and the Christian spirit must permeate every department of hospital life — moulding its every new technological achievement into the older Christian tradition, thus making it truly effective. It is only in this way that our model hospitals of the future will justify their architects' high hopes and satisfy too that most difficult of all groups to serve or please — the sick folk.

The third World Congress of Psychiatry will be held in North America for the first time, when it meets in Montreal June 4-10, 1961. Among the 3,000 delegates from 62 nations, will be representatives from psychiatry and allied fields e.g. general medicine, psychology, biochemistry, nursing, sociology, anthropology, social work and pharmacology.

Information regarding the program and registration may be obtained by writing the General Secretary, III World Congress of Psychiatry, 1025 Pine Avenue West, Montreal 2, Quebec.

* * *

If anyone thinks it is fun to hold a full-time job; take care of a three-room apartment; go to school five nights a week; and humor a husband on the side — he's right! There's positively nothing like it to keep one from being bored or lonesome.

— *The Hearing Eye*, Vol. 28, No. 3

A CHANGE IN ATTITUDE

REGINALD S. BENTLEY, R.N.

QUESTION: *What feelings and attitudes did you have about mentally deficient children before you came to work at the Provincial Training School? How have they changed, if they have, and why? Do you think they will continue to change?*

RETICENCE on the part of many nurses to work in an institution for the care of the mentally retarded child arises mainly from two widely held misconceptions. The first is a belief that nothing can be done for such children. The second is a belief that there can be little or no sympathy between a normal person and a mentally defective child. As a result of these beliefs an attitude of repugnance is often aroused even though, in many cases, the nurse has never come face to face with such children.

Mr. Bentley is a supervisor at the Provincial Training School, Red Deer, Alberta.

At the Provincial Training School in Red Deer a three-year course in mental deficiency nursing is given to the nursing aide and male attendant staff. Both the staff and the trainees benefit greatly as a result of this course. The change in attitude becomes increasingly evident in most cases, as the individual member gradually attains seniority. This change was expressed with warmth and sincerity in the following essay written in answer to the examination question which forms the heading of this article.

THE STUDENT'S ANSWER

ANNA V. NIELSEN

Before I came to work at the Provincial Training School, I had never been in close contact with mentally deficient children. I knew about them, saw them on the street, and once in a while met parents who had a mentally deficient child. I am thinking of one particular family to whose home I was invited. I was really curious to see this girl, six years of age. As I arrived at the house, I heard frightful screams that really upset me and I wondered what I was going to see. However, it was not what I had imagined. A beautiful little girl was sitting on the floor. She looked just the same as a normal child, but she was unable to talk. She could only utter these screams and other strange noises. There were no apparent physical abnormalities. I felt very sorry for the child and the family. I wondered what could have caused this condition. I also wondered how it was possible for the parents to love the child. It seemed to me that she received more affection and care than the other children did.

Mrs. Nielsen, a second year student aide, is a new Canadian who has had to learn to express herself in English since her arrival in Canada.

It was with mixed feelings, therefore, that I started to work at the P.T.S. I had heard many rumors about the School. Indeed, someone was kind enough to inform me that I would not be able to stand working there, and would not be there long. But they were wrong!

I started in the infirmary. The first thing that I had to do was to help feed the patients. Yes, I will admit I didn't feel too happy about the work that first day. However, when I had been there a few days and had become accustomed to the other trainees and the work, nothing seemed to bother me. A few days later, I picked up a small child and, holding her in my arms, I wondered if I ever would be able to feel any affection for her. This child was an idiot. As I got to know each child and got used to the different ways of handling them, something happened to me. Naturally, I felt sorry for them,

but that feeling gave way to something deeper. To my surprise, I found that I had really become attached to them. Those children, condemned to live in an institution, have the same feelings as normal children. They laugh, they cry, they get irritated, annoyed. They hate and they love. Therefore, they are trained the same as normal children. They are taught good manners, cleanliness and kindness.

Having worked now for over two years, my attitude certainly has changed. I like my work and find it very interesting. I am sincerely attached to the children and love to work among them. They have been cut off from close contact with their parents and the love which only a mother and father could give; therefore, love and kindness is very important to them. With love, affection and a secure environment in which to live, they are usually quite happy.

I do not think my attitude toward these children will be reversed. As I continue my training, gaining more knowledge and understanding, I am convinced that if it does change, it will be for the benefit of the children.

Trends in the Promotion of Oral Health

R. S. LANGSTROTH, D.D.S., F.A.C.D.

With a dentist-to-population ratio in Canada of 1:3000, what is being done and what can be done to promote dental health?

OVER THE LAST DECADE, government and health planners have shown an increased interest in oral health. Prior to the advent of federal health grants, only two or three persons in Canada were engaged full-time in the promotion of oral health. There are now two or three dozen. By contrast there are over 5000 dentists in Canada whose time is taken up almost exclusively with the correction of the ravages of dental diseases.

Two of the problems involved are the lack of adequate base-line data and the complexity of the cause or causes of dental diseases. The first is being overcome fairly rapidly. Although we are still operating on theories that science has not yet been able to translate into facts, more and more facts are being correctly fitted into the theoretical jigsaw puzzle. We are making progress, our proximity to a solution being dependent on individual optimism.

The funds available for dental research are gradually increasing, although the proportion of total funds for research in the health sciences is small. However, we are reaching a point where financial assistance is a smaller problem than the availability of trained personnel who are willing and able to devote a lifetime to dental research.

Dr. Langstroth is Director of Dental Health for the province of New Brunswick.

Oral Problems

Stated simply, dental disease is of two kinds, tooth decay, and infections and inflammations of the gums. Tooth decay is a major problem up to 30 or 40 years of age and then periodontal disease takes precedence, although it is often a problem at an earlier age. Irregularities of the teeth or malocclusion make up the third great problem.

Dental Decay

Dental caries during childhood are not only a major problem in themselves, but decay and its end results also have a marked effect on the amount and degree of gum diseases and the numbers of irregular teeth that occur at all ages.

Dental decay is as yet an unsolved complex but the best theory to date suggests the following process:

Normal bacteria present in the mouth thrive on fermentable carbohydrates

which, when introduced into the oral cavity, produce an acid that is strong enough to disintegrate the enamel covering of the teeth. This process is influenced by:

1. The degree of hardness of the tooth substance,
2. the strength of acid produced which partly depends on the buffering effect of saliva and the rate of bacterial growth,
3. the retentive factor of foods taken into the mouth (highly refined flours and sticky carbohydrates are suspect) and,
4. the length of time this process is allowed to proceed undisturbed by brushing or rinsing.

Dental Public Health

In the light of these presently accepted theories, public health personnel are concerned with prenatal and postnatal nutrition in the hope of building stronger tooth structure. The selection of foods is based on knowledge of the environment that particular foods create in the mouth. A reduction of sugars and highly refined flour products is urged and an increase in fibrous, self-cleansing foods.

Dental public health workers encourage improved oral hygiene, particularly in regard to reducing the time between eating or drinking things that are potentially caries-dangerous and the time of rinsing or brushing. Sound clinical research is being promoted on potential enzyme inhibitors, bactericidal substances and acid-neutralizing agents that might favorably alter the salivary environment. There is also an interest in substances that increase the resistance of the enamel to attack, such as fluorides, and finally, in the preservation of all teeth possible, by conservative dental treatment.

By a combination of health education and dental treatment, more of the child population is receiving improved dental care. All provinces have some form of subsidized dental care available for some children. We are a long way from complete coverage in any province. A few are providing dental care for the welfare group. In any province this is the group that is likely to receive dental benefits first because its need has already been recognized by government agencies.

Parents who are able to provide dental care for their children are being urged to do so, and an endeavor is being made to have government at some level — local, provincial or national — provide dental services for the balance. The problem of personal motivation in the field of nutrition, oral hygiene and regular dental care is a difficult one.

From the standpoint of public health workers, the approach to dental problems might be arranged in the following order — health, function, comfort (absence of pain), appearance. In general, the public still arranges this complex in reverse order — appearance, comfort, function, health. Consequently, a large proportion of practising dentists are forced to approach their patients' problems in somewhat the same order. Dental treatment is definitely a form of dental education. Considering the volume of dental care provided daily and annually in Canada, it is only natural for the public to consider dental care as a treatment problem. Further, dental treatment is a personal matter. In addition, preventive measures are general in nature, although personal in application. A specific is lacking.

In Canada the advance of social security in the health field has been slow and fairly orderly but definite and inexorable. Hospital care insurance is an accomplished fact. Medical care insurance has already reached the hustings. This seems to presage a more rapid approach to inclusion of nursing care and dental care in the plans of the social security minded. All this puts the spotlight on dental treatment and consequently on those who are trained to provide it.

Dental Personnel

In 1959 there were 5780 dentists in Canada. The ratio of dentists to population was 1:3000 ranging from 1:2400 in Ontario and British Columbia to 1:10,000 in Newfoundland. In common with other professions, they were poorly distributed within the provinces, the urban centres showing a much better situation than rural areas.

Recently, a new dental faculty was opened at the University of Manitoba, the first new dental school in Canada

in about 35 years. The five other dental faculties have experienced varying degrees of enlargement and expansion. The prediction is, that with the anticipated increase in population, there is likely to be a worsening of the dentist-population ratio unless training facilities are still further increased.

Traditionally, dentists have had auxiliaries in the form of a secretary /receptionist/chair assistant usually called a dental assistant or dental nurse. The majority of them are apprentice-trained by the dentist, some are registered nurses and a very few have a diploma in dental nursing.

In addition there is a group known as dental technicians who may be employed by a dentist but more often are set up in their own business quarters and render services to many dentists in an area. They process artificial appliances to the prescription of the dentist and are paid by him. The majority of these technicians are well organized into ethical provincial associations. They provide an excellent and necessary auxiliary service to the dental profession.

In recent years, particularly in Canada, some dental technicians, who call themselves by the newly-coined term of "denturists" or "public denturists" have presumed to deal directly with the public in the provision of artificial appliances. They then use this illegal practice as evidence of experience and training, and appear before provincial legislators requesting legal status. This has occurred in at least four provinces. In Saskatchewan, they were granted such status about one year ago. Very recently, this decision was reversed and at the present time no such provision exists in any province. This experience has left the dental profession rather shocked and bewildered at the attitude of our legislators.

In recent years, dental hygienists have been introduced into Canada. They are usually two-year diploma, university-trained personnel whose activities are confined to dental inspections, scaling and cleaning teeth, topical applications, taking x-rays, and health education. They were employed first in the public health field. Although their number is few, they are being looked on with favor by the private practitioner and more of them are finding a place in dental offices. In both situations, they have amply demonstrated their usefulness. There is a definite shortage of this type of auxiliary personnel.

Recently, the province of Alberta announced plans for the introduction of a new type of auxiliary to the dentist. It is planned to give a two-year course at the University of Alberta for the training of "dental auxiliaries." These persons will perform the functions now carried out by dental hygienists, but in addition they will be trained to fill cavities that have been previously prepared by a dentist. They will only work in the field of public health under the supervision of a dentist. It is hoped by this method to greatly increase the volume of dental care, particularly in rural areas.

Manitoba recently announced a different type of auxiliary. That province has delegated to dental hygienists, in addition to their field as originally stated, the task of taking impressions of the mouth and repairing artificial dentures.

To those not familiar with dental problems this sounds confusing. In fact, it is confusing even to those in the field. What does it mean? Primarily, it means that health planners are already thinking of the problems of oral health in relation to the implementation of complete health care.

The B.N.A. Act gives the provinces control of their own health services. In the light of a national social security philosophy, it also provides a built-in "divide and conquer" environment for health planners.

Obviously, the planners are ahead of the profession. Insofar as the development of more auxiliary help is concerned, it is a logical reaction to a self-evident need. However, developing a new and untried type of auxiliary for any profession should be "experimented" with in a much smaller area than a province. It seems unlikely that the project will receive enthusiastic support unless more than one province and preferably the entire country is a field for employment.

While these "trends" are perhaps well-intentioned will they "promote oral health?" They will if more dedicated personnel are available for and

devoted to the improvement of oral health. They will not if dilution of the dental profession is enforced by any discipline other than the profession itself. All this will sound familiar to Canadian nurses who have struggled for years with the problems of different levels of personnel.

Summary

This discussion of dental problems has been confined largely to the last decade and to the field of public health.

I have touched on the basic problems which, after hundreds of years, still remain to be solved, although during that time much knowledge has been gained. I have pointed out some of the social pressures which are occurring with such rapidity. All of this is in the hope that it will arouse your curiosity and perhaps your desire for a more detailed study of specific dental subjects.

Oral Microbiology in Health and Disease

C. E. VAN ROOYEN, M.D., F.R.C.P.(C.)

The data discussed emphasize the necessity for cultivating habits of good oral hygiene from the early years of life. The evidence reveals the value of careful visual observation and regular bacteriological examination of the mouth during illness.

IN HEALTH, THE MICROBIAL flora of the mouth may exhibit wide fluctuations in the number and type of commensal organisms present from day to day. Various factors such as age, improper diet, feeding habits, living conditions, cold and damp weather, may increase bacterial flora.

A representative sample of the oral microbial population is readily obtainable by swabbing the back of the mouth and throat cavity with a sterile cotton wool swab. Thereafter the specimen is subjected to bacteriological cultivation, and the organisms thus isolated, to antibiotic sensitivity. It is also customary to obtain scrapings of individual lesions such as dental abscesses, suspected fungal, leutic or other lesions, and to examine these by direct microscopic staining methods as well as by darkfield illumination.

About 29 species of microorganisms have been recognized as inhabiting the mouth, oropharynx and nasopharynx both in health and disease. These may be conveniently dealt with by dividing the organisms concerned into groups of genera and species and then discussing the diseases associated with them.

Dr. van Rooyen is professor of bacteriology at Dalhousie University and Victoria General Hospital, Halifax.

The Cocci

The cocci are probably the most prevalent group of organisms in the oral flora of the Canadian population. These consist of streptococci, staphylococci, pneumococci and certain Gram negative micrococci such as Neisseria *catarrhalis* and more rarely Neisseria *meningitidis*.

In normal health any of these organisms may be present in small numbers. However, with the advent of disease they multiply rapidly and not only cause damage to the tissues of the gums, tongue, buccal surface, tonsils and fauces, but also to the accessory air sinuses. The injury may spread further afield and extend down the respiratory tract to involve the trachea and bronchial passages. In short, it may be asserted that certain organisms whose normal habitat is in the buccal cavity where they behave as commensals, may also be capable of playing a role as active pathogens under circumstances unfavorable to

the host. They are able to produce a variety of lesions, ranging from a slight to a very severe tonsillitis with risk of septicemia and endocarditis.

Healthy human carriers of antibiotic-resistant staphylococci and other organisms pose a tough problem for our modern hospitals. Although such carriers exhibit no overt signs of ill health, they nevertheless constitute a potential hazard to the open wounds of patients with whom they may come in contact. At the moment, there appears to be no effective method of controlling such infection. Many patients admitted to hospital today carry antibiotic-resistant infections that have defied treatment in general practice. A never-ending stream of antibiotic-resistant organisms is constantly being introduced into the modern hospital environment. A return to stricter, old-fashioned antiseptic and aseptic techniques of handling surgical wounds seems inevitable.

Factors favoring the transition from a commensal to a pathogenic role may range in character from such causes as general debility, anemia, and exposure to intracurrent viral infections such as influenza, the common cold or adenopharyngeal-conjunctival infection. Traumatization of tissue by extraction of septic teeth or removal of tonsils and adenoids, could also change the environment of the organisms by providing them with the opportunity to invade temporarily devitalized tissue. Factors favoring the transition of microorganisms from the commensal to the pathogenic state are not fully understood. For example, Neisseria *meningitidis*, the causal organism of cerebrospinal meningitis, may occur as a commensal in the nasopharynx of normal healthy subjects without producing any visible signs of local or general damage. However, this same organism is potentially capable of invading the blood stream and meninges and causing severe, often fatal, cerebrospinal meningitis in certain individuals. This happens for no apparent reason.

During the 1940 epidemic of meningitis that affected the British Expeditionary Force to France, the carrier rate among healthy military hospital ward personnel soared to 90 per cent. Carriers of *C. diphtheriae* had been known to exist previously and may still persist in the area. It is probable that after inception of antibiotic therapy there was some change in the pattern of the bacterial flora of the oropharynx in the mass of the population. Such inference is justified by the over-all reduced incidence of such diseases of the past as pneumococcal pneumonia and endocarditis where the causal organism was usually harbored in the normal mouth. The spectacular declines in the incidence of cerebrospinal meningitis, lobar pneumonia and scarlet fever are partially due to the inability of the respective causal organisms to develop resistance to antibiotics, and in part to a reduction in the volume of these organisms carried in the oral flora of the population at large. Conversely such organisms as staphylococci, which have shown a capacity to resist antibiotic action, have tended to flourish.

The Bacilli

Both in health and disease, the bacilli play a less important role in oral microbiology. In health Lactobacillus *acidophilus* is probably beneficial in helping to maintain the normal microbial balance of the human body. It is present from the cradle to the grave. Certain species produce lactic acid and almost all ferment carbohydrates present in food. Many attempts have been made to incriminate lactobacilli as the predominant agent of dental caries. It is now appreciated that other physical, microbial and chemical factors are also implicated in tooth decay.

B. *proteus*, Pseudomonas *aeruginosa*, Aerobacter *aerogenes and* Escherichia *coli* are not usually found in the healthy mouth. Their habitat is confined to the gastrointestinal and urinary tracts. The appearance of these organisms in the mouth portends faulty general hygiene or severe debility. In general, these conclusions are more applicable to the adult than to the infant. The milk diet of the latter tends to alter the balance towards greater prevalence of coliform organisms.

In the past, Hemophilus *influenzae* was encountered with relative frequency in the mouth during the winter

weather and, in particular, during outbreaks of viral epidemic influenza and acute respiratory disease. It is possible that the widespread use of penicillin may be responsible for the reduced incidence of H. *influenzae* as a cause of oral disease. In infants and children, it is quite possible that Hemophilus *pertussis* may occur in the mouth during an attack of whooping cough, but H. *pertussis* is not primarily responsible for oral infection.

Acid-Fast Bacteria

Caution should be exercised in interpreting the significance of acid-fast bacilli found in the oral cavity. In cases of pulmonary tuberculosis their presence is due to an obvious cause. Under other circumstances, lesions of the mouth should not be ascribed to M. *tuberculosis* without careful culture and animal inoculation tests. In the tropics, lesions of the oral cavity may be caused by M. *leprae*, the causal organism of leprosy. Diagnosis is usually established by biopsy and histological examination for intracellular M. *leprae* organisms.

Spirochetes

Numerous non-pathogenic commensal spirochetes of the genus Treponema are found in the normal mouth. In septic states such as gingivitis, alveolar abscesses and dental caries, their numbers may multiply greatly and so aggravate the patient's misery.

The condition called Vincent's angina is generally thought to be due to a spindle-shaped microorganism B. *fusiformis* operating in conjunction with a relatively large spirochete, Borrelia *vincentii*. The clinical designation of Vincent's angina probably embraces a range of closely related clinical conditions affecting the mouth, gums and tongue, under the broad heading of necrotizing ulcerative gingivitis. Contributory factors in etiology are faulty personal oral hygiene, overcrowded living conditions, improper diet, malnutrition and vitamin deficiency. The disease was common in military camps and establishments of World War I when the name "trench mouth" was used as a popular descriptive term.

Following the discovery of penicillin, syphilitic lesions of the mouth have greatly diminished over the past two decades. Common sites for development of chancres are the lips, tongue, the palate and muco-buccal folds. Lesions may either be primary or secondary to genital syphilis. They may also appear as manifestations of congenital syphilis such as delayed dentition, abnormal development of the upper central incisors and first permanent molars, termed Hutchinsonian incisors and mulberry molars. The incisors tend to be widely separated with crowns converging toward the incisal edge and are popularly referred to as pegged teeth. The final diagnosis in all suspected luetic lesions of the mouth, is by means of the complement fixation, precipitin and immobilization tests. These should never be neglected.

Mycotic Infections

Increasing importance is being devoted to fungal infections of the mouth. Bacteriologists have become more alert to the detection of early lesions. Actinomyces *bovis* is stated to occur as a normal inhabitant of the tonsillar crypts.

Very rarely, as the sequel to a dental surgical operation, infection of a tooth socket may ensue. More often than not, infection may develop spontaneously without obvious reason. Lesions may develop on the gums and later extend to the mandible or maxilla. Necrosis of tissue occurs with formation of pus containing small yellowish specks resembling sulphur granules. Later, extensive granulation tissue and sinus formation may develop.

The diagnosis is established by obtaining a specimen of pus from the lesions and examining it for colonies of fungus under the microscope. It is also cultivated for the presence of Actinomyces *bovis*.

Moniliasis

It is thought that normal human commensal strains of Candida *albicans*, a yeastlike organism, could cause disease under special circumstances. The latter include riboflavin deficiency, chronic debilitating illness such as cancer, tuberculosis, diabetes, measles, scarlet fever, typhoid fever, leukemia, prolonged medication with potent

drugs, x-rays or radium therapy. The condition manifests itself in adults as a bilateral erosion of the labial commissures, sometimes referred to as "perleche." Deep fissures develop and these become covered with gray exudate. In infants, oral moniliasis is called "thrush." Infection is believed to be contracted at birth. In adults, oral monilial infection may be subacute or chronic, appearing as white, cream or grayish-colored plaques on the mucous membrane of the mouth.

Histoplasmosis

Lesions due to Histoplasma *capsulatum* may cause ulceration of the tongue, lips or buccal mucosa. They have been said to resemble the lesions of tropical kala-azar and cancrum oris. Diagnosis is established by histological biopsy, a search for H. *capsulatum* bodies, attempted cultivation on Sabouraud's media, and skin tests for sensitivity of the patient to histoplasmin antigen.

Blastomycosis

Chronic granulomatous lesions of the mouth may be found in the South American variety of Blastomyces *braziliensis*. The North American counterpart Blastomyces *dermatididis* does not usually produce ulcerations of the mouth.

Geotrichosis

This is a very rare disease of the mouth due to Geotrichum infection. White patches may develop on the mouth and are difficult to distinguish from the lesions of thrush. Diagnosis is established by attempted cultivation or direct microscopic examination of scrapings for fungus.

Viral Infections

Probably the most frequently encountered infections of the oropharynx are viral in origin. Although diagnostic techniques for viruses have greatly improved within recent years, they are still not readily available to the bulk of the public. In all probability the bulk of viral infections of the mouth and adnexa evade recognition.

Recent opinion tends to suggest that most cases of acute tonsillitis are more likely to be caused by viruses than by bacteria. Specific viruses are the adeno, herpes, infectious mononucleosis, Coxsackie, ECHO (enteric cytopathogenic human orphan) and poliomyelitis varieties. All of them may be isolated by obtaining a throat swab and infecting tissue cultures. Many other viral agents are probably involved in oral infection. These include the agents of mumps, measles, rubella, rubeola, varicella, vaccinia, variola and the group responsible for the common cold syndrome.

Acute viral respiratory disease and epidemic influenza play a major part in infection of the paranasal sinuses. The extent of the asymptomatic viral carrier state in health is not known. However, there is one well known example in salivary gland virus that is excreted from the salivary gland of many normal healthy adults. It is also capable of transmission to newborn infants in whom it may cause severe or fatal disease, or a chronic debilitating condition.

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SPHYGMOMANOMETERS

A 20-page booklet on blood pressure measurement, entitled "Sphygmomanometers — Principles and Precepts," is now available free of charge. Nurses, who use this instrument daily, will find this booklet particularly valuable. It provides fundamental knowledge of the functioning of the sphygmomanometer and the reasons behind established standards and techniques. The easy-to-follow text is supplemented with drawings and diagrams illustrating important principles of measurement. Copies are available on request from the: W. A. Baum Co. Inc., Copiague, N.Y.

Cancer and Leukoplakia of the Mouth

ARTHUR L. MURPHY, M.D., F.A.C.S.

The author proves that an ounce of prevention is worth more than a pound of cure.

THINK OF THE HUMAN BODY as a cylinder with thick walls and an open core down its centre from top to bottom. The outer layer of the cylinder is the skin, protective and excretory in function. The inner layer is the mucosa of the gastrointestinal tract, largely absorptive. The mouth is the top opening of the tube, the anus the lower one. Metabolically, at least, the anus is clean. It disposes only of chemically and bacteriologically-made waste products, while the mouth, exposed as it is to the outside world, is dirty.

Since chronic irritation is the main contributory cause of cancer, it follows that the mouth, thus exposed, must be a likely site. It is. The farther into the mouth we go, from lips to tonsils, the more malignant the type of growth that may develop. This is partly because the lymphatic drainage from the tongue, the floor of the mouth and the pharynx is richer than that from the lips. It is also due, in part, to man's vanity. The chronic ulcer on his lip that he looks at in his shaving mirror each morning will send a man hastily to his doctor. The same ulcer, hidden just around the corner on the buccal surface, painless and out of sight, is too often allowed to develop to a later stage before seeking advice. Another reason for the apparently rapid development of these lesions is that they occur most often in the elderly who lack the initiative and the incentive to do anything about them in the early stages.

Chronic Irritation and Cancer

Cancer probably starts in a single cell which, for an unknown reason, has overcome the restraint put upon it by the parent tissue of which it is a part. But there is one important secondary factor that may present itself in many forms. This is chronic irritation.

1. *Infection* A startling example of this is syphilis. In over 50 per cent of untreated cases of tongue syphilis, cancer develops. More important irritants, because of their frequency, are the little infections around dirty, carious teeth.

2. *Lack of teeth* Elderly people are often edentulous. With proper dentures, all is well. With ill-fitting dentures, there is chronic irritation. Without dentures at all, there is constant irritation to the mucous membranes from chewing food requiring mastication.

3. *Chemical irritants* In the mouth this means tobacco, particularly chewing tobacco. The elderly smoker, when he has lost the last of his teeth capable of holding a pipe, will often turn to this.

4. *Dietary deficiency* Physiologically it is established that the elderly require more protein than in youth. Often they eat less. Physically they tend to be inactive and hunger does not prod them strongly. Often they are poor and protein foods are more expensive, as well as being more difficult to prepare. Again, if they are edentulous, the common proteins are hard for them to eat. So they settle for the easy way which, for their mouths as well as for their whole bodies, can be the unhealthy way.

5. *Hormone deficiency* Here, as in determination of the basic cause of cancer, we are in unknown territory, but the relationship between breast, prostatic, and other forms of cancer and hormones has been proven. I believe it likely that a hormonal deficiency has its influence in the mouth as well although it has not been as noticeable. In the Nova Scotia Tumor Clinic we have seen definite improvement result from the use of ovarian and testicular hormones in treating hyperkeratosis of the skin in the elderly.

Incidence

Cancer of the mouth is more common in the male than in the female. There are probably several hidden reasons for this but there is one obvious, important reason. The female

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ages better than the male. She is not a productive citizen today, relegated to the chimney corner, useless and unwanted, tomorrow. The inactivity into which she slips in her later years as her right, is a gradual process and not one that is thrust upon her. The result is that as she grows older she maintains a deeper interest in life and greater personal vanity. She is more likely than her husband to have good teeth, her own or dentures, and to wear them. If she develops a sore in her mouth, her vanity will urge her to seek advice. It is the old man, unoccupied, without interests, and with a dying pride, who presents himself too often when his oral malignancy is far advanced.

Treatment

The diagnosis of oral cancer rests with the pathologist. A cancer of the mouth can grow as much in a day as cancer of the breast in a week; as much in a week as cancer of the breast in two months. Thus there is not time to apply clinical observation or trial therapy to a chronic ulcer in the mouth. If it does not respond to the simplest treatment in a maximum of two weeks, its exact nature must be determined by biopsy.

Treatment of oral cancer is by excision. In superficial lesions of the lip equally good results may be obtained by Roentgen radiation or radium. In other areas such measures are reserved for cases already beyond the hope of surgical cure. In growths of the tongue, the floor of the mouth, the inferior alveolar margins and the sulci, the operation is combined with a radical dissection of the nodes of the neck on the same side. In cancer of the lip and superior alveolar margins, a node dissection is done only when there is evidence of involvement. In patients who have been diagnosed early and treated adequately, prognosis is good. But more important for curative purposes, than radical surgery, is prophylaxis and early diagnosis. It is here that the nurse often has the opportunity to play a more crucial role than the surgeon.

Leukoplakia

The red, warning flag of impending oral cancer is really white. It is leukoplakia. Between 25 and 50 per cent of cases with, or about to develop, oral cancer wear this danger signal. It is produced by an overgrowth of the cells of the mucous membrane, a degenerative overgrowth. Unlike cancer cells, leukoplakial cells are still under the control of the mucosal tissue. They have the same characteristics as normal mucosa. They are not malignant but they are abnormal and lead to a malignant breakdown.

Leukoplakia is identical, histologically, with the thickened, brownish patches of hyperkeratosis often seen on the face in late middle years and old age. Hyperkeratosis may break down into basal cell carcinoma. The breakdown of leukoplakia is far more malignant. It presents as a slightly raised, white patch. It may be small; it may be extensive. It is not to be confused with the white blanching sometimes seen under a tightly fitting denture, and certainly not with a bit of food stuff or mucus lying on the membrane. It is often associated with a deeply fissured tongue, and with cracked, dry, scaling lips.

The treatment for leukoplakia is to remove it, preferably by excision or, if it is too extensive, by destruction with the cautery.

Prophylaxis

After these observations on oral cancer and the people who develop it, we can draw up a fairly precise scheme of prophylaxis.

1. All elderly people should have frequent oral examinations. These can be done quickly, with a good light and a tongue depressor.

2. Treat all carious teeth and even mild oral infections *promptly*. After the age of 40, they encourage the development of cancer.

3. Every male and female, from the age of two years, should have good teeth to chew with — their own or, lacking them, artificial dentures.

4. Dry, scaling lips should be protected. Moistening them with saliva aggravates the condition. The proper prophylactic measure is a lipstick. Men can use a colorless one.

5. An adequate dietary intake is essential for a healthy oral mucosa. This demands sound teeth and an understanding of food needs. Vitamin supplements

are not necessary if the diet is adequate. They may serve as a safeguard if there are doubts about the individual's nutrition.

6. A healthy mouth in a healthy body demands a modicum of happiness. The elderly person (this applies particularly to men) must have a job to do, something of which he is capable, something which keeps him productive.

7. Tobacco can be very irritating to an unhealthy mouth. But remember, to deprive an old man of his pipe, while decreasing the risk of cancer, may cause greater harm. (At least, avoid the mistake that I once made. Looking into my old patient's mouth and seeing the telltale, dark brown stain in the sulcus, I stood back in rage. "Are you chewing tobacco?" I demanded. He smiled at me benignly and nodded. "You told me to give up the pipe," he said.)

8. Patients with leukoplakia should be referred for excision or cauterization.

9. Any ulcer of the lips or mouth of several weeks' duration does not need a trial of conservative treatment. *It needs immediate biopsy.*

To Better Serve our Patients

SISTER MARGUERITE DU CHRIST-ROI, p.s.p.

When a public health nurse attends university her experiences there will contribute in unexpected ways to her future work in the community.

IN THE COURSE OF THE last half century, public health has made progress. By the application of current scientific knowledge we are able to relieve humanity of much of the burden that disease imposes. Each year, the results of research projects in public health, offer new ammunition in the war for the preservation of health. The preamble to the constitution of the World Health Organization states that the possession of good health is one of the fundamental rights of every human being.

The citizen of today has become increasingly aware of his rights and special duties regarding health and now demands protection from disease from organized society (the state). For its part, the state must integrate a health program into its general plan of social reconstruction. All progress in matters of health depends primarily on the way in which national, regional, and local services are controlled. Moreover, progress cannot be realized without the understanding and participation of an informed population. Active, collective participation will increase the public interest and assure more lasting results.

The spreading of information regarding methods and procedures that will help the individual and the population-at-large to conserve and improve their health, is the responsibility of every health worker. In a dynamic society such as ours, which tends to bring a new orientation and order to everything that concerns the activities and affairs of men, health education cannot remain unchanged. The problems of our times are community problems; logic indicates that we try to solve them by collective means — to fuse our activities.

Each year, workers from associated health disciplines gather together at university schools. Their view-points are very different, and doubtless it is a good thing they are, but the essential thing is that they are able to mingle harmoniously in the pursuit of common objectives. Courses in general psychology, sociology; the study of social problems; the teaching and practice of public health methods; health education of the public: the theory, its application and essential techniques — all of these open vast horizons for

Sister, a member of the order of the Little Sisters of the Presentation, prepared this material while she was enrolled in a course in public health nursing at the University of Montreal.

each of us to ponder our personal methods of working in order to improve them.

As well as this knowledge, field observation visits furnish an opportunity to become acquainted with community resources, to appreciate the methods of operation approved by official, voluntary and private agencies. These experiences, as well as providing useful information, are always an opportunity to admit to consciousness what "the others" do, who work in the same spirit as we do. These enriching encounters in the area of human relations prepare us for a cooperation wisely undertaken.

A nurse who is devoted exclusively to patient care in the home and is aware of the demands of her profession will derive much benefit from these academic studies. When she goes into the homes she will find exceptional opportunities for improving health through her teaching. She has contact with families at the very moment that they are seeking help to solve particular problems.

The nurse who enters into the heart of family life while giving care, brings tangible and concrete comfort which wins for her the confidence of the whole family. From that time on, the constructive teaching she offers, not only to the patient but others in the home, is far more effective and a far cry from being moralizing and boring. This type of instruction goes beyond the usual confines of health teaching and has as its goal the prevention of illness, and the preservation of health. At the same time the nurse shows the family how to care for their patient. When the family case worker, the social worker and the nurse work together in joint service to indigent families, a strong bond is created. Their ideas, initiative, and combined energies crystallize into a unique and captivating task: integrated regeneration of the family.

Whether it is in thickly populated urban areas, in "suburbia," in a rural community, or in the remotest depths of the underdeveloped countries, the methods of approach to problems of illness are identical. Wherever ignorance and disease cause confusion, hard times, and suffering there is work for the nurse to do.

As well as collective effort and research in public health teaching at the family level we try to sow the rudimentary seeds of health knowledge. This education will be the breach through which we can promote health services that are objectively realistic; the route toward the promotion of a state of complete well-being, physical, mental and social for every person.

IN THE GOOD OLD DAYS

(*The Canadian Nurse* — FEBRUARY, 1921)

The University of Alberta has announced a course in public health nursing.

* * *

Maternal nursing was considered of such great importance to the child that a number of towns in France provided food, shelter and a small sum of money for every woman who agreed to nurse her own child.

* * *

One striking example of the efficacy of modern medicine is the marked result obtained in the prevention of typhoid fever. In the South African war, the deaths totalled over 8,000 in 57,000 cases of the disease; in the Spanish-American war, of an army of over 100,000 men, 20,734 suffered from the fever. During the recent war, there were only scattered cases or occasional small groups.

* * *

Is the trained attendant a necessary factor in the health program of a community? Personnally, I think she is. This is an age of specialization.

More and more we find nurses turning away from the private duty field in order to direct their attention to some special line of work. The field of public health nursing has thrown open many doors. There is such a demand for nurses in the field of preventive medicine that the training of another type of person to assist in the care of the sick in the homes becomes more urgently imperative.

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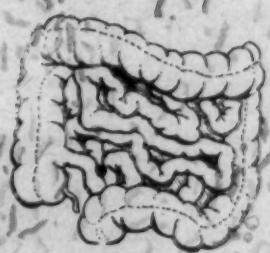

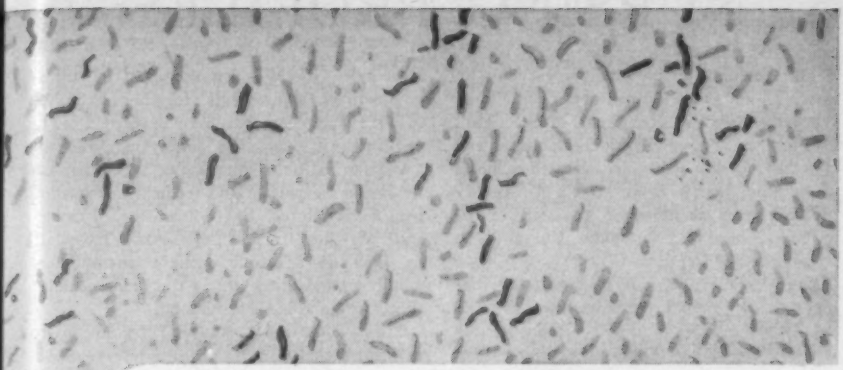

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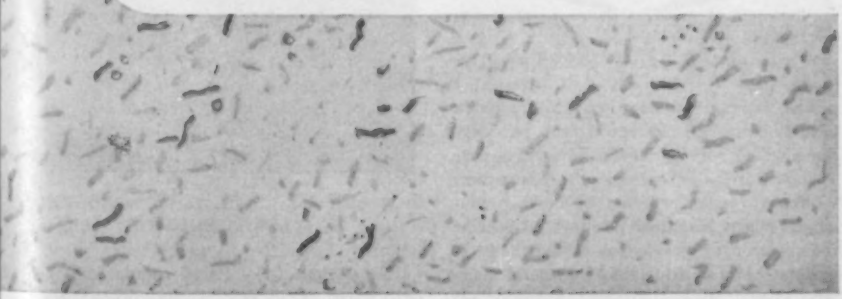


NURSING PROFILES

The position of inspector of schools of nursing in Ontario has been filled by **Dorothy Rowles**, a graduate of St. Paul's Hospital, Saskatoon. Saskatchewan-born and educated, Miss Rowles obtained her bachelor of nursing degree from McGill University in 1958, then remained on the staff of the McGill School for Graduate Nurses as a lecturer in nursing until 1960.

Her earlier professional experience has included considerable administrative responsibility. She is a former matron of the Union Hospitals of Eatonia and Spiritwood, Saskatchewan. While working in Montreal, she acted as chairman of the program committee for the Instructors' Group, ANPQ. Her present duties will entail an exacting schedule of travel, supervision and counselling. Her favorite off-duty activities — reading and camping — will provide pleasant relaxation.

MARY MODERWELL

The school of nursing, Metropolitan General Hospital, Windsor will be long-remembered for its famous interval as the Demonstration School for the experiment with a two-year program of nursing education. **Mary Kathleen Moderwell** became the director of the school during 1960. A graduate of Chatham Public General Hospital, Ont., Miss Moderwell obtained her diploma in nursing education from the University of Western Ontario in 1955, completing requirements for her B.Sc.N. in 1958. Her time has been devoted almost exclusively to nursing education, first as assistant instructor in nursing arts, then as instructor in science and medical nursing in her Alma Mater. She joined the teaching staff of the Metropolitan General Hospital in 1958 as assistant director in nursing education and instructor in the fundamentals of nursing and medical nursing.

Miss Moderwell has taken an active part in local association activities as corresponding secretary, Windsor-Essex chapter and chairman of the special committee on nursing service and nursing education. Her off-duty interests are as varied as her professional ones. They include a special delight in music and photography.

Vera Louise Spencer has been appointed a public health nursing supervisor, Division of Public Health Services, Sask. Department of Public Health. Since her graduation from Regina General Hospital, she has obtained her bachelor of nursing degree from McGill University and her master's degree in public health nursing from the University of Michigan, Ann Arbor.

(Sask. Photo Services)

VERA SPENCER

Her present appointment culminates several years of service in her chosen field. She began her public health career as a

staff nurse at North Battleford, moving on to Prince Albert in 1951. In 1954 Miss Spencer was appointed regional nursing supervisor for the Prince Albert health region, leaving in 1958 for the same post with the Yorkton-Melville unit. As a nursing sister, RCAMC, she served in Canada and England, 1944-46 and received the Canadian Volunteer Service Medical and Star in recognition of her contribution.

A keen community worker, she has contributed her assistance to organizations for crippled and retarded children, and mental health. She is a keen sportswoman in her free time, taking particular pleasure in golf, badminton, curling and fishing.

Hazel Katherine Wilson has joined the Division of Public Health Nursing, Ontario Department of Health, as a regional supervisor. Following her graduation from the Ottawa Civic Hospital, Miss Wilson did general duty nursing and ward supervision for a few years before undertaking advanced study. She obtained a diploma in public health nursing from the McGill School for Graduate Nurses, a diploma in administration and supervision in public health nursing from the University of Toronto where she also completed requirements for her B.Sc.N. during this past year.

HAZEL WILSON

Her career in public health nursing began in 1944 with the Alberta Department of Health. This was succeeded by a year as health instructor at the Winnipeg General Hospital and two years' service with Carleton Health Unit, Ontario. From 1951-59 she was P.H. supervisor for the District of Kenora H.U., leaving there to complete her postgraduate studies.

Betty Eleanor Hailstone is now assistant director of nursing service, Regina Grey Nuns' Hospital. She graduated from its school of nursing in 1945 and has since obtained her diploma in administration of hospital nursing service from the University of Saskatchewan.

(Vienna Photo Studio)

BETTY HAILSTONE

With the exception of a few years spent in general duty nursing at St. Peter's Hospital, Melville, Sask. and Kelowna General Hospital, B.C., Miss Hailstone has devoted her professional services to her Alma Mater, chiefly as a head nurse. Her familiarity with the hospital and her experience in ward administration have prepared her well for this senior post.

Myrna Eileen Clarke has joined the public health nursing staff, Toronto Department of Public Health as assistant director. A Nova Scotian, Miss Clarke came to the University of Toronto School of Nursing for her professional preparation graduating with her B.Sc.N. in 1951. This had been preceded by five years as a school teacher in her native province.

She already has several years experience with the Toronto Department of Public Health to her credit, beginning as a staff nurse in 1951, then as an assistant supervisor 1954-56, and most recently as educational consultant 1956-60.

In 1924 a young graduate of Brantford General Hospital, holidaying in Lethbridge, Alta., was asked to do relief nursing with the local Nursing Mission. This marked the beginning of an interest in public health nursing that eventually led **Adella McKee** into a 33-year career with the Victorian Order of Nurses. This career was recently brought to a close by retirement. She has been district supervisor of the Winnipeg branch since 1927. During that time she has seen the service expand from eight to 26 nurses with a fleet of nine cars presently available.

Friendly and unassuming, Miss McKee takes little credit for the growth of the Winnipeg branch but the high regard in which her services have been held by the Order and by the city of Winnipeg tell a different story. A VON scholarship granted to her in 1931 for postgraduate study at the University of British Columbia gave tangible proof of appreciation.

Retirement will give her an opportunity to enjoy the Winnipeg home which she shares with her mother and sister, and permits time for travel which she enjoys. In company with the many friends that she has made among her professional colleagues and in the community, we wish her a happy future.

Katherine M. Bailey has retired from professional activities after 13 years as director of nursing, West Coast General Hospital, Port Alberni. She is a graduate of Edmonton General Hospital with a diploma in hospital administration from the University of Toronto. Her career has included administrative duties in hospitals at Saltspring Island, Salmon Arm, Ocean Falls and Powell River, B.C. and in several Saskatchewan hospitals. She was a director of B.C. Hospitals' Association for several years as a representative of the province's nurses. Her interest in and practical assistance to students doing university field work resulted in her appointment as a clinical instructor and honorary member of the academic staff of the University of British Columbia School of Nursing. One of her leisure-time interests has been the local Soroptomist Club of which she is a past president.

Her professional abilities will be greatly missed. Warm good wishes are extended to her for a pleasant retirement after a very busy and productive career.

The attitude of questioning — curious, open but persistent, expecting understanding — is the only dynamic that heads securely for the target of knowledge and intelligent action . . . a society which does not respect this dynamic ignores its greatest resource, for itself as a whole and for its individual members . . . adult education — reaching parents, teachers, and others who can make this attitude contagious and provide its proper challenge and support among their own generation and the rising one — seems the chief medium through which it could be communicated.

Those who seriously embark on education as adults, have taken a new role in society — that of persons who have *put themselves in the way of questioning;* from being simply responsive to or reacting against patterns of thought, action and feeling received from their younger training to being ones who question their experience, to understand it, to act on their understanding of it.

— *Citizenship Items,* September, 1960

* * *

90 per cent of all baked goods is made from enriched flour.

— *CAC Bulletin,* October, 1960

Brotherhood Week will be observed February 19-26. It is sponsored by the National Conference of Christians and Jews which came into being in 1928 in order "to promote justice, amity, understanding and cooperation among Protestants, Catholics and Jews, and to analyse, moderate and strive to eliminate intergroup prejudices which disfigure and distort religious, business, social and political relations, with a view to establishment of a social order in which the religious ideals of brotherhood and justice shall become standards of human relationships."

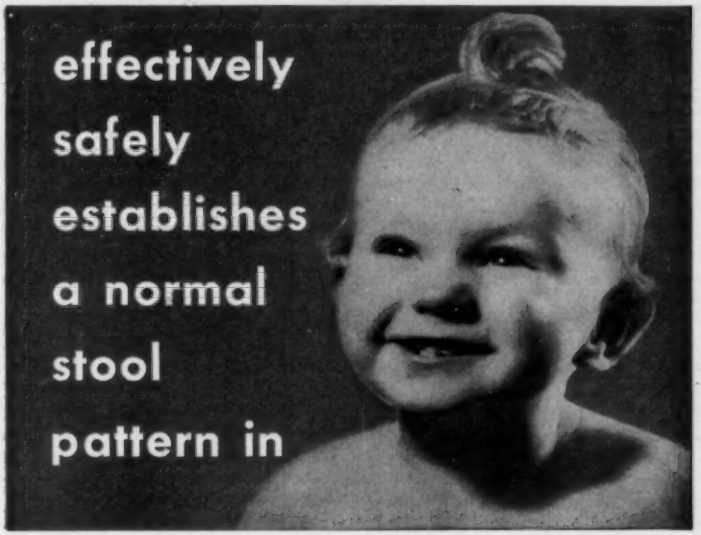
* * *

Perhaps the most valuable result of all education is the ability to make yourself do the thing you have to do, when it ought to be done, whether you like it or not; it is the first lesson that ought to be learned, and, however early a man's training begins, it is probably the last lesson that he learns thoroughly. — THOMAS HENRY HUXLEY

* * *

It is easy to say how we love new friends, and what we think of them, but words can never trace out all the fibres that knit us to the old friends. — GEORGE ELIOT

Baby's Own Tablets



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THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
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Your National Committees

Last month we noted in this column the various meetings of national committees that were held in National Office in November. This could be considered an era of "firsts." It was the first time two large national committees, Nursing Service and Nursing Education, met together. It was the first time a national committee held its meeting in the Council Room of the Royal College of Physicians and Surgeons. Because of this, members of National Office had the opportunity to meet more frequently with CNA members from across Canada.

Perhaps it was the spacious and luxurious surroundings of the Council Room, or perhaps it was the trend of the times. Anyway, the deliberations of these meetings indicate exciting times in nursing for the future. As a result of the recommendations contained in the Report of the Pilot Project on the Evaluation of Schools of Nursing in Canada, several steps in future planning in nursing were proposed.

Discussion at the joint meeting of the committees on Nursing Service and Nursing Education centred mainly around the implementations of Recommendations II and III. HELEN MUSSALLEM, who directed the Pilot Project, interrupted her studies at Columbia University to attend this meeting and to participate in the discussion. A committee composed of two members from each committee with Helen Mussallem and LILLIAN CAMPION from National Office will prepare Canadian criteria for the evaluation of schools of nursing. Considerable work has already been done provincially and this preliminary work will be used as a basis for the completed project.

This group will also consider the kinds of tools that could be prepared and made available to schools wishing to evaluate their present educational programs with a view to self-improvement; and make suggestions as to how these tools might be used. Another task for this group is to formulate suggestions concerning the use of advisory personnel to those schools of nursing wishing to participate in a school improvement program.

Criteria must be established before embarking on a study of the quality of nursing service. A member of National Office staff will be delegated to do the preliminary preparation on this project. It is then visualized that a committee will be appointed to formulate criteria. Committee members discussed the possibility of a study similar to the Pilot Project on the Evaluation of Schools of Nursing in Canada, followed by a reassessment of the criteria used and the development of permanent criteria.

The Committee on Nursing Education discussed the need for a National Guide for Curriculum Development. You will recall that this need was expressed two years ago because of the variety of methods being used provincially in curriculum planning. A review of curriculum activities, at this time, indicated that the provinces have now completed or are in the process of developing provincial curriculum guides. Several members stated that they had found the material prepared by the Planning Committee from the Curriculum Workshop, held in Ottawa in Autumn 1959, and the Report of this Workshop, helpful. It was decided that the sub-committee would

compile this material and make it available, through National Office, to all nurses in Canada.

The Committee on Nursing Service discussed the preparation of a pamphlet on the interpretation of Home Care Plans. Discussion on the kinds of in-service education programs that are available and useful in health agencies pointed up the need for a bibliography on this subject. The preparation of a statement of the philosophy and beliefs about nursing in Canada was also discussed.

At the meeting of the Special Committee on Nursing Assistants the preparation of a pamphlet interpreting the role and functions of the nursing assistant to nurses and other health workers was discussed. This committee also considered the relationship of the nursing assistant to the organized profession.

International Council of Nurses

The ICN has always sought to help nurses to improve standards of patient care. Its Nursing Service Committee has made this matter one of its special concerns and has encouraged national nurses' associations to study special aspects of nursing.

The publication *ICN Basic Principles of Nursing Care* is the culmination of this whole activity. This paper brilliantly describes the care required by a patient which is determined, not by diagnosis or by therapy, but by fundamental human needs. This publication should be read by all who care for patients in hospital, in patients' homes, in public health, and also by all who are responsible for nursing education.

ICN Basic Principles Of Nursing Care; price 3 shillings or 50 cents, can be obtained from the ICN House, 1 Dean Trench Street, London S.W.1., England or from the Canadian Nurses' Association, 74 Stanley Avenue, Ottawa.

ICN Congress

More than 1,000 nurses, representative of nursing from most parts of the world have applied through their national associations to attend the ICN Twelfth Quadrennial Congress.

The Governor-General of Australia, Lord Dunrossil, will officially declare the Congress open on April 17, 1961. Viscountess Dunrossil has accepted the invitation to be Patron of the Congress.

At the first Plenary Session on April 20, the theme, "Wisdom and Guidance through Professional Organization," will be presented by DR. MARIE JAHODA, PH.D., a Social Psychologist; and by MISS ALICE GIRARD, M.A., immediate Past President of the Canadian Nurses' Association.

On April 21, Congress participants will meet in four sections, devoted to Nursing Education, Nursing Service, Public Relations and Economic Welfare. In each of these sections there will be three speakers, who will present papers on subjects related to the main topic of the section. Each section will organize a panel discussion following the presentation of papers. Delegates will be able to choose which section they propose to attend.

The Royal Australian Nursing Federation has arranged for a bank in Melbourne to open a special account for those who wish to transfer currency to Melbourne in advance of their visit. Any such money should be sent to the Bank of New South Wales, Nursing Congress Agency, c/o 368 Collins Street, Melbourne.

A New Beginning

Ex-SAMNS members will be interested in nursing progress in South Africa. The District Nursing Service, a branch of the Johannesburg Hospital has been recognized as a training school for the Certificate in District Nursing of the South African Nursing Council. This is the first district nursing course to be started in South Africa. This six-months' post-basic course is open to general nurses and midwives registered with the South African Nursing Council.

A South African College of Nursing to serve all nurses of whatever race, color or creed, and open to nurses from Basutoland, Bechuanaland, the Rhodesias, Swaziland and other countries, was decided upon at the Congress of the South African Nursing Association in October. This multi-racial college of nursing will have a tremendous impact on nursing development in Africa.

Division Of Nursing, USA

The U.S. Public Health service has announced the establishment of the Division of Nursing within the Bureau of State Services, effective last September 1. MARGARET G. ARNSTEIN, an internationally recognized leader in the field of nursing, heads the new Division of Nursing which brings together two nursing units, the Division of Public Health nursing and the Division of Nursing Resources. All functions of the two former nursing units will be continued in the Division of Nursing and other functions will be added as developments indicate the need to assume new areas of responsibility.

National League for Nursing

The NLN has scheduled its 1961 convention for Cleveland, Ohio, April 10-14 on the theme "Interaction — Key to Nursing Progress."

ANA Conferences

The American Nurses' Association is sponsoring four conferences on the improvement of nursing practice in February and March, 1961. All areas of nursing care will be covered. Advance registration is required.

Apply to:

Sectional Regional Conference,
American Nurses' Association,
10 Columbus Circle,
New York 19, New York.

In Memoriam

Kathleen (MacDonald) Brenda who graduated from the School of Nursing, University of Alberta in 1953 died on June 21, 1960 from injuries received in a fire. She had been on the staff of the City Health Department, Edmonton following her graduation.

* * *

Amelia G. Child, a 1916 graduate of Vancouver General Hospital, died in 1960.

* * *

Gwendolyn Edith (York) Cook who graduated from Vancouver General Hospital in 1918, died late in 1960.

* * *

Maggie Craig, a graduate of the Winnipeg General Hospital in 1923 died October 28, 1960. She had been engaged in private nursing.

* * *

Aileen Mary Foley, who graduated from the Ottawa General Hospital in 1930, died in 1960.

* * *

Mary Eulalia Ann (Lang) Gubbels who graduated from St. Michael's Hospital, Toronto in 1953, died October 10, 1960 while on a holiday trip to England.

* * *

Myrtle Blanche (Watson) Gernaey, a graduate of Vancouver General Hospital in 1933, died October 8, 1960. She had nursed for many years at the V.G.H. and most recently had been a supervisor in the Willow Chest Centre, Vancouver.

Florence Evelyna (Blake) Heighway, a graduate of Havera General Hospital, New Zealand in 1923, died in Powell River, B.C. in August, 1960. At one time she was director of nursing of the Powell River Hospital.

* * *

Mae (Marshall) Howe, a graduate of Sault-Ste-Marie General Hospital, Ont. in 1923, died during 1960 at Parry Sound, Ont.

* * *

Marjorie Helen (Stewart) Jamieson who graduated from Regina General Hospital in 1931 died recently in Cabri, Sask.

* * *

Irene Florence (Finnucaine) MacLeod who graduated from St. Paul's Hospital, Vancouver, B.C. in 1940 died during 1960.

* * *

Lillian MacMillan, a graduate of St. Luke's Hospital, Bellingham, Washington in 1917 died in Vancouver on August 25, 1960. During World War II she served with the Canadian contingent of nurses sent to military hospitals and hospital ships in South Africa. She became director of the Red Cross outpost hospitals in B.C. in 1950, the position which she had held at the time of her death.

* * *

Mary Margaret McClory who graduated from Hotel Dieu Hospital, Windsor in 1918 died during 1960.

* * *

Margaret J. McInnis, a 1928 graduate

of the Hospital for Sick Children, Toronto died November 15, 1960 after a long illness. She had been assistant registrar of the Central Registry of Graduate Nurses, Toronto for some years.

* * *

Margaret Jean McKee who graduated from Medicine Hat Municipal Hospital, Alta. in 1951 died in a car accident on November 12, 1960. For the past three years she had been on the staff of the Vancouver General Hospital.

* * *

Irene Grace Munro who graduated from Lakeside Hospital, Chicago in 1914 died in Toronto on October 7, 1960. She had worked as an office nurse.

* * *

Kathleen (Cregan) Ring who graduated from Regina Grey Nuns' Hospital in 1938, died October 8, 1960. She had served overseas with the RCAMC as a nursing sister during World War II.

* * *

J. Marjorie Ross, a graduate of the Montreal General Hospital in 1914 died on November 15, 1960. She had served overseas during World War I with the CAMC.

* * *

Rose A. Roy who graduated from Youville Training School, General Hospital, Ottawa in 1930, died October 30, 1960. She had been a public health nurse in Blind River, Teck Township and most recently in Sturgeon Falls, Ont.

* * *

Martha Vivian (Dodd) Scott who graduated from the Ontario Hospital, New Toronto in 1940, died August 15, 1960. She had recently been engaged in nursing with the Victorian Order of Nurses.

* * *

Sister St. Léon, a graduate of St. Vincent Hospital, Toledo, Ohio in 1908, died November 14, 1960. She had been on the staff of Notre Dame Hospital, Montreal for several years as a supervisor.

* * *

Muriel Alice Wilkinson who graduated from St. Paul's Hospital, Vancouver in 1918 died during 1960. She had engaged in private nursing until March, 1959.

* * *

Mary Margaret Willis, a graduate of Queen Elizabeth Hospital, Birmingham, England, who came to Canada in 1957, died September 15, 1959, during a holiday visit to her home. While in Canada she had worked in St. Michael's Hospital, Lethbridge and the Calgary General Hospital.

Saskatchewan Student Nurses' Association

Representatives of the student nurses in Saskatchewan met together for the first time in May, 1959, at the annual SRNA meeting. An adviser, Miss E. James from Regina was appointed by the provincial association to help the students to organize a provincial group. A tentative executive was appointed to draw up a constitution. Its members were limited to the various Saskatoon hospitals to facilitate meeting.

By December 1959, a constitution was ready for reading by the SRNA council. It was found that minor changes were necessary. With the assistance of the adviser the tentative executive prepared a second draft of the constitution which was accepted by the council.

In May, 1960, the students' association became an official organization under the name of the "Saskatchewan Student Nurses' Association." The aims of the SSNA are to promote interschool relationships, compare student education programs, and promote interest in the mother-group, the Saskatchewan Registered Nurses' Association.

Members of the 1960-61 executive are: Gwen McDonald, University Hospital, Saskatoon, president; Joan Dyer, Union Hospital, Moose Jaw, Mary Shea, Grey Nun's Hospital, Regina, vice-presidents; Bernice Peterson, City Hospital, Saskatoon, secretary; Lois Sonstelie, Holy Family Hospital, Prince Albert, treasurer. Miss James will continue as adviser.

The new council held its first meeting in September 1960 at the University Hospital, Saskatoon. Representatives from each of the 11 schools of nursing in Saskatchewan were present. A program of educational topics, public service projects and social activities was planned. There is much enthusiasm being shown in the association and the future looks rosy for the SSNA.

SOCIOLOGY APPLIED

SUZANNE GIROUX *and* JACQUELINE OUIMET

Sociology is beginning to take its rightful place in our schools of nursing. Nurses need to know about the environment from which their patients come and the social problems that may affect them.

ALL TOO OFTEN illness is the result of social conditions — poverty, ignorance and so forth. The nurse in the course of her work will be in contact with those in deep distress. Frequently she will be the confidante of patients who will discuss their troubles freely with her and ask for her advice and assistance. It becomes a necessity, then, for her to know something about the welfare laws of the province — or at least know of their existence — since such knowledge might be instrumental in resolving difficulties.

The best way to find out how much nurses know about such matters would seem to be through questioning. Several hundred student nurses from Quebec's French-language hospitals were given the following situation questions and asked to state how they would deal with them.

1. A 65-year-old nurse is unable to work through physical disability. Could you give her any information about the old age pensions law that could be applied helpfully here?
2. What do you estimate is the cost of your education as a nurse to:
   a. Yourself or your family
   b. your hospital

The answers to the first question showed great variety. "I would tell her to contact the ANPQ" or "I would refer her to the social service department of the hospital" were acceptable statements since they showed some initiative although the students were obviously lacking in knowledge.

After an analysis of replies one could say that a third of the students had answered intelligently; another third had rather vague knowledge of the existence of such a law; the remainder did not have the slightest inkling that such legislation existed and could make no suggestion that might have helped the nurse either directly or indirectly.

Students who advised the nurse to consult governmental authorities in Washington or in Ottawa seemed to be totally ignorant of provincial autonomy and the fact that laws concerning education and health arise from this level of government although there are certain areas of agreement with the federal government.

The second question, concerning the cost of nursing education, was well discussed. Each student's answer was influenced by her own viewpoint, interests and motives. No particulars have been added to or subtracted from this question but the compilation of data will furnish the information necessary for a memo to various sources offering financial aid to students. Hospitals employing few or no general duty nurses but who depend almost entirely on students for nursing service can operate their schools at a margin of profit. Costs can be very high in institutions that respect the aims of the school of nursing.

We do not pretend to offer an answer to this situation. We simply present the thinking of several hundred French-language student nurses.

Cost of Nursing Education for the Student or her Family

121	students estimated	....	$ 300-$ 500
107	"	....	500- 1000
51	"	....	1000- 2000
21	"	....	2000- 3000
104	" had no estimate or gave a ridiculous answer ranging anywhere in amount from nothing to $10,000.		

Cost to the Hospital

65	students estimated	.....	$ 500
128	"	.....	1000
41	"	.....	2000
22	"	.....	3000
148	" had no estimate.		

A large number of students discussed the cost of nursing education in a very sensible, practical way. One girl who had worked prior to enter-

Miss Giroux and Miss Ouimet are official visitors to French schools of nursing in the province of Quebec.

ing a school of nursing noted her expenses in detail.

Bank balance at start of course.. $1000
Expenses — First year 450
" — Second year.... 300
" — Third year 450

This same student evaluated her service to the hospital

First year no value

Second year ½ of the salary of a graduate nurse

Third year ¾ of the salary of the graduate nurse

In hospitals providing affiliations with other agencies, this girl noted that the services of the student nurses would benefit them as well.

About 50 students considered that the service they gave to the hospital would balance the cost of their education. They seemed unanimous in their satisfaction with the curricula. Several noted "that nothing had been spared in assuring their professional development."

What conclusions can be drawn from this little study? The answer is, nothing of special merit. It has simply shown that:

1. Students nurses who are all very young as a general rule, lack experience of life. This is quite a normal state.

2. If the social laws with which every nurse should be familiar are not taught in our schools, the student nurses will not know how or when to put them into practice.

3. The importance of public health affiliation lies in the fact that the student nurse learns at first hand what types of problems may arise and how the law may help to resolve them.

Certain recommendations can be made to the Curriculum Committee and to directors of nursing education. These are:

1. That the curriculum should include study of social welfare laws such as those relating to public assistance, family allowances, needy mothers, workmen's compensation, old age pensions and allowances for the blind or disabled.

2. That the curriculum should also include information concerning the cost of living such as the cost of a day's hospitalization; the price of meals; the cost of laundry, of education.

We would also recommend as a teaching method, the presentation of actual cases. Textbook study can be very dry but solving a real problem through the application of suitable legislation will leave a picture in the nurse's mind that she can readily recall. The social worker can be a participant in this part of the school's program.

As a final step, student nurses should be acquainted with the part played by income taxation in meeting social welfare needs. This will have more meaning for them later when they too are salaried and taxable employees.

We would hope that the end result of such study would be increased awareness that man is a part of the society in which he exists; that society actually exists for him. As graduate nurses the students will become part of a professional body whose task is to protect its members so that they may serve society effectively.

According to a report in *The Modern Hospital* the results of a national survey show that the average cost of preparing meals per patient per day ranges from a low of $2.11 in city, county and state hospitals in the southern and southwestern United States to $5.88 in hospitals of 250 or more beds in the western states.

— *The Modern Hospital*, November, 1960

* * *

A man who has not found happiness cannot impart it to others. We can only give what we have. Happiness, grief, gaiety, sadness are by nature contagious. Bring your health and your strength to the weak and sickly and you will be of use to them. Life alone can rekindle life.—MARCUS AURELIUS

* * *

On November 1, 1960 the Royal College of Nursing entered upon a new phase in its history. As a result of amendments and alterations to its charter, membership has been extended to include all registered nurses of either sex.

— *Nursing Times*, Vol. LVI, No. 44

* * *

During adolescence and early adult life, accidents outrank every other cause of death among women.

— Metropolitan Life Insurance Company

Benign Prostatic Hypertrophy

JOANNE MARIE MONTALBETTI

This is a condition found frequently in elderly men. Improved methods of treatment and care have made relief from it more certain in spite of the age factor.

MR. BLANK, 75 YEARS OLD, was admitted with a diagnosis of prostatic hypertrophy. This is a hyperplasia or overgrowth of one or more of the lobes of the prostate gland. The gland surrounds the urethra and its increase in size readily obstructs the flow of urine. It is a very common condition in males over 60 years of age. The cause is obscure.

Mr. Blank suffered from frequency that had developed gradually over the years. This particular symptom is due initially to the reduction of bladder capacity by muscular hypertrophy of the wall. Later bladder atony occurred and was accompanied by retention with overflow. The patient also experienced nocturia and, at the time of his admission, he reported that he got up to void seven times, at least, during the night. This symptom had been present for five years. Nocturia is due to the same factors that cause frequency. In addition, Mr. Blank complained that he had difficulty in initiating voiding, or hesitancy. Sometimes three-quarters of an hour was required before he began voiding. There was dribbling of urine since the enlarged gland was causing increased interference with the mechanism of urination. This resulted in mounting residual urine and dribbling.

Other signs and symptoms that are sometimes present in patients with this diagnosis are: Hematuria, dysuria, increasing slowness of voiding, and pain in the lower back, legs, perineum and rectum. If the patient develops severe obstruction and acute retention, he may develop bladder diverticula, cystitis, stones, hydronephrosis, pyelonephritis and eventually uremia. Death usually follows.

Mr. Blank's admission urinalysis, blood count, and temperature were normal. A blood urea nitrogen test is routine in this hospital for all urological patients. When obstruction is sufficiently severe, kidney function is affected and the waste products remain in the blood. The blood urea nitrogen test (BUN) measures the amount of these wastes. The normal is 8-15 mg. %. Our patient's level was 22 mg. %.

An intravenous pyelogram (IVP) followed. A dye (Hypaque) was injected into the brachial vein of the arm and a series of x-rays were taken to observe irregularities in the tract and to determine the length of time required by the kidney to excrete the dye. The report indicated:

> No density suspicious of urinary calculi. No gross dilatation or distortion in either upper urinary tracts. No diverticula.

Physical examination proved that Mr. Blank was a good surgical risk.

Treatment

When acute retention is present, catheterization is a necessity and an indwelling catheter is used to prevent recurrence of retention. Such procedures were unnecessary in this instance. The patient was put on forced fluids to help prevent urinary tract infection; to relieve strain on the kidneys, and to prevent dehydration.

Intake and output records are useful in checking on the function of the kidneys. They assist in early detection of retention and ensure that an adequate supply of fluid is being taken.

Medications

Mr. Blank received sodium seconal prior to surgery and for a few evenings postoperatively for its hypnotic effect. Thiosulfil was given to help prevent urinary infection. The toxic symptoms of Thiosulfil are similar to those of the other sulfa drugs with the exception

Miss Montalbetti is a graduate of the University of Alberta Hospital, Edmonton.

that it is more soluble in urine and therefore it does not form crystals and cause kidney damage as readily.

Nursing Care

This was Mr. Blank's first experience in hospital. His independent nature made this sudden need for others to care for him a source of acute embarrassment. The physical condition involved added to mental discomfort.

Since many of his nurses were younger than his own daughters, he felt shy about asking for their help or even discussing his symptoms with them. One of our first concerns was to help him feel comfortable in the strange environment. Meeting other patients of his own age who had similar conditions was a comfort. Since nocturia was one of his problems, even knowing where the bathroom and necessary light switches were relieved his anxiety. Unavoidable dribbling caused him considerable worry because of possible odor and his desire to be clean. We tried to solve this by emphasizing that this was an expected symptom and that it was very important for us to know if his bed or clothing were damp in order to keep his skin healthy.

Preoperative investigative tests required explanation, as did the operative procedure itself. Fear of the unknown produces stress and it is being increasingly recognized that having the patient go to the operating room in a relaxed frame of mind is a prerequisite to successful surgery.

We applied tensor bandages to Mr. Blank's feet and legs before he was taken to the operating room. This measure has been found useful in promoting adequate circulation, especially when the patient's legs are in lithotomy position. It is also of interest to note that, because of his age, Mr. Blank did not receive preoperative medication. One of the possible postoperative complications for the aged is hypostatic pneumonia. Avoidance of the depressant effects of drugs is a preventive measure.

The orderly carried out a minor skin preparation that extended from the umbilicus to one-third of the way down the thighs. Special attention was paid to the cleanliness of the umbilicus since it can be a source of infection. On the same evening Mr. Blank was given a soapsuds enema. Ordinarily, he would have been placed on forced fluids for the evening preceding his operation but since the intravenous pyelogram was carried out just before surgery he had nothing to drink after supper since fluids would have diluted the dye and dimmed the x-rays.

On the morning of operation, the patient had no breakfast. He was encouraged to walk about before the intravenous pyelogram in order to free the intestine from gas that could blur the x-rays. Following the IVP Mr. Blank was taken to the operating room.

The Operation

A transurethral resection was performed under spinal anesthesia. Blood loss was controlled by electrocoagulation and a special irrigating fluid, Cytal. The resected pieces of prostatic tissue were also washed out with this fluid. A bilateral vasectomy was done. This is the surgical removal of a portion of the vas deferens, to prevent spreading of infection to the epididymis. A two-way Foley catheter was left in the bladder to permit drainage and irrigation. A continuous normal saline irrigation ran postoperatively. This kept the bladder free from blood that might clot and occlude the catheter. The irrigation was discontinued one day postoperatively. The catheter was left in place, for simple urine drainage. Frequent bladder irrigations ensured a patent drainage system and a clean bladder.

A blood transfusion, given in the operating room, compensated for blood loss during the operation and prevented postoperative shock.

Postoperative Care

Mr. Blank returned from the O.R. shortly after noon. His indwelling catheter was attached for continuous irrigation. The solution was regulated at 60 drops per minute and had been warmed to prevent bladder spasm. The catheter tubing was pinned to the drawsheet so that kinking was prevented. There was sufficient slack to permit the patient to move comfortably in bed. Mr. Blank was conscious. His general condition was good. He was encouraged to eat but the nurse fed

him since he was not to sit up in bed for at least six hours in order to prevent a "spinal headache." His blood pressure and pulse were checked every 15 minutes until stable, and then every hour.

While his legs were still numb from the effects of the anesthesia the nurses turned him q.1-2 h. He had a slight chill early in the afternoon but this is quite common after this operation because of blood loss. Extra blankets and a hot cup of tea were satisfactory remedies. His irrigation was checked frequently for proper function and the character of the drainage noted. Had there been much bleeding the speed of the irrigation would have been increased. If blood clots had occluded the catheter, bladder irrigations would have been used to clear the blockage.

We encouraged Mr. Blank to move about in bed, to breathe deeply, and to cough. These are all measures useful in preventing skin and circulatory complications, hypostatic pneumonia and urine stasis. Good skin care was an important nursing measure. Fluids were forced day and night up to 3,000 -5,000 cc. Intake and output records were helpful in maintaining a proper fluid balance and in estimating renal function. Urine excretion is normally about two-thirds of the oral intake. The drainage bottle was emptied q.8 h. and the contents measured accurately.

The continuous irrigation ran for 24 hours. When it was discontinued, Mr. Blank received a tub bath with the assistance of the orderly. A sterile dressing was placed over the end of the plastic drainage tubing and secured with an elastic band. The tubing was draped over the edge of the tub to prevent contamination of the inside of the catheter with bath water. When Mr. Blank was up walking about the ward, the end of the catheter was protected in a similar way and the clamp on the catheter pinned to his gown. Care was taken not to leave the catheter clamped for more than 20 minutes at a time during the immediate postoperative period in order to prevent distention of, and bleeding from, the raw prostatic bed.

While the indwelling catheter remained in position, manual irrigations were done regularly for bladder cleansing. Sterile technique for this procedure is very important. These patients are prone to infection largely because of the constant irritation produced by the catheter on the delicate mucous membrane lining.

Three days postoperatively the catheter was removed. Several hours later Mr. Blank voided a satisfactory amount with fairly good control but experienced some burning sensation. This was to be expected and was due to catheter irritation. During the following days, a daily tub bath helped to ease local discomfort, relieve bladder spasm, and prevent retention.

A routine hemoglobin and hematocrit were done on the third postoperative day. Hematocrit is the percentage of packed red blood cells to the total blood volume. If this percentage is low, the patient is given blood. Mr. Blank's percentage was within normal limits. Urinary control continued to improve. Burning, frequency and other symptoms of discomfort disappeared.

Health Teaching

The importance of drinking plenty of fluids (at least three quarts a day) and of reporting to his doctor immediately should there be any recurrence of signs and symptoms was emphasized. Good personal hygiene, adequate nutrition and sufficient exercise are important to the health of every one. We discussed with Mr. Blank how much more important these factors would be for him in relation to his future health.

This patient's prognosis is good. At the time of the transurethral resection, the tissue was noted as "clinically benign" thus ruling out cancer. However, in future years the prostate may again hypertrophy and a second operation may be necessary.

Reading is not an exercise or an act of penance, but something that holds for us the assurance of a better way of life. There are no formal educational requirements for admission to the reading elite. You just start reading; reserve the time necessary, and go on from book to book.

— *Royal Bank Monthly Letter*

Her mother might help, but

SHE'D RATHER TALK TO YOU ABOUT PIMPLES

Only two people easily available to the adolescent can offer advice with assurance that it will be gratefully accepted. One is the mother and the other is the nurse in school, doctor's office, or elsewhere. Actually, the nurse, because of her professional stature and knowledge, can help where a parent often fails.

There is now a clinically-proved medication for pimples* which you can recommend with confidence... CLEARASIL Medication. Many nurses do in fact suggest CLEARASIL —as a recent survey of readers of *RN, A Journal for Nurses,* indicates.

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*Original clinical reports in our files.

CANADA'S LARGEST-SELLING PIMPLE MEDICATION . . . BECAUSE IT REALLY WORKS

AUSTRALIAN CONGRESS

The 12th Quadrennial Congress of the International Council of Nurses at Melbourne in April will be the largest and most representative international gathering of nurses ever held in Australia. The Royal Australian Nursing Federation is preparing for an attendance of 3,000 nurses. The New Zealand Registered Nurses' Association will be joint hostess for the Congress.

Delegates or observers are expected from all of the 63 countries whose national nursing organizations have full membership and from most of those with associate membership.

The Congress will see the admission of 12 additional countries to full membership. Some are countries that only recently have achieved their independence. Their admission indicates the general improvement in nursing standards throughout the world since 1957. During the past 10 years there has been a close relationship between the nursing profession in Australia and the developing countries of Asia and the Pacific. Partly through the Colombo Plan and other mutual assistance programs, there has been a steady flow of nurses from Indonesia, Thailand, the Philippines, India, Pakistan and Malaya to undertake postgraduate nursing courses in Australia. Others have come to take their general training.

Australia, a country of over 10 million people, has about 40,000 nurses. Although Florence Nightingale did not visit that country, her influence was important in establishing the nursing profession. In 1868, in response to a request from the New South Wales government, Miss Nightingale sent out one of her trainees, Miss Lucy Osborn, and five other sisters to work at Sydney Hospital. Miss Osborn's appointment marked the beginning of the Nightingale system of nursing in Australia.

Australia is a federation of six sovereign states. Nursing throughout the country has developed along the same pattern. State nursing associations were founded at the turn of the century. The Royal Australian Nursing Federation was established in 1924. The RANF has been affiliated to ICN since 1937.

Nursing is highly regarded as a career for women in Australia. A girl must be at least 17 years old before she can start her general training in any of the states. She must complete a minimum of three years' training and pass a state final examination before being eligible for registration. After gaining a

(Australia News and Information Bureau)

Melbourne

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Left colon catharsis can be achieved in *two to five* minutes without causing pain or spasm,[1] while affording the same cleansing efficacy as the usual enema of one or two pints. Reverse flow and leakage are prevented and a comfortable flow rate assured by the construction of the anatomically correct plastic tube.

Each Single-Dose Disposable Unit contains, in each 100 cc.:

Sodium acid phosphate USP.....16 G.
Sodium phosphate USP..... 6 G.

Plastic "squeeze-bottles" of 4½ fluid ounces, with prelubricated tip.

1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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MONTREAL CANADA

general nursing certificate, a nurse normally takes midwifery training and later obtains a third certificate in infant welfare.

There is a wide variety of nursing opportunities in Australia. A nurse can work in hospitals, clinics, the armed forces, industry, district and "outback" nursing services and in Australian dependencies such as Papua, New Guinea. Each suburb and township has its infant welfare centre established by state authorities. It is staffed by registered nurses who are responsible for advising the mothers of the district. Mothers bring their babies to the clinics for regular free check-ups. Mobile clinics serve isolated areas.

Vast expanses of Australia's 3,000,000 square miles are sparsely settled. Special services have been developed to provide nursing care in settlements too isolated or too small to have their own doctors or hospitals. These are the Bush Nursing Services. "Bush" is an Australian word that is applied to the less settled regions. The Bush Nursing Services operate hospitals and centres in these areas. The nurses sometimes go on calls that may take them many miles. They must have midwifery training as well as a general certificate and, of course, they need a streak of adventure.

These services are closely allied to the Royal Australian Flying Doctor Service. "Outback" settlements, cattle stations and mining camps keep in touch with the Flying Doctor bases by radio. In emergencies an aerial ambulance can be called to fly in a doctor or to take a sick person to hospital.

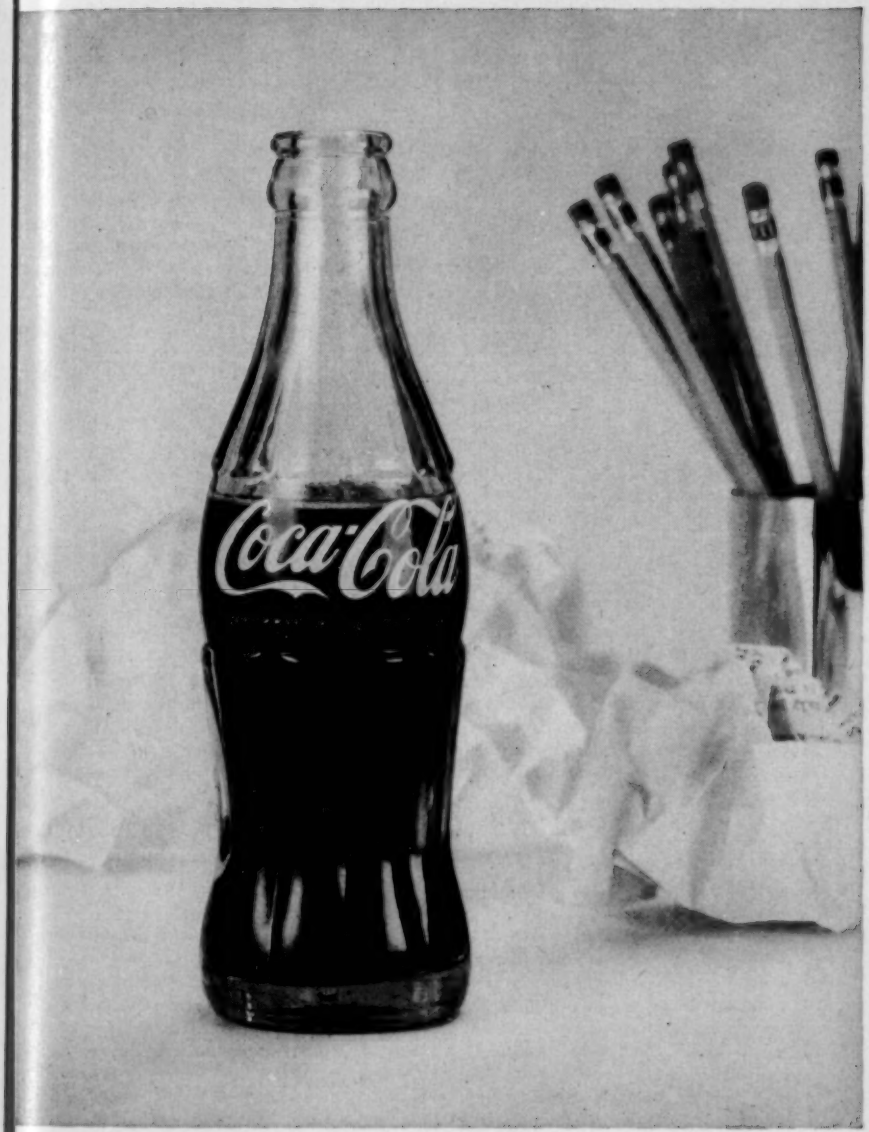
The Australian population is increasing at an average annual rate of 2.5 per cent, a figure excelled by few countries. Immigration in the last 12 years has brought 1,000,000 new settlers from the United Kingdom and Western Europe, making the population more cosmopolitan. The rise of manufacturing has led to the rapid outward development of the major cities and has changed the pattern of employment. Today about 30 per cent of the work force is employed in factories.

The Congress will be held in Melbourne's largest indoor arena in the Exhibition Buildings. Melbourne, a city of about 1,800,000 people, has been the venue for a number of international congresses this past year.

An extensive network of air, rail and road services puts Melbourne within easy range of resorts and holiday centres throughout Australia. A wide variety of tours will be available for visiting nurses. They include such places as the placid lakelands of mountainous Tasmania and the magnificent subtropical surf beaches of Queensland's Gold Coast. —News and Information Bureau, Commonwealth of Australia.

(Australia News and Information Bureau)

Sydney



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Book Reviews

Recreation in Total Rehabilitation by Josephine L. Rathbone, Ph.D. and Carol Lucas, Ed.D. 398 pages. The Ryerson Press, 299 Queen Street, Toronto 2B. 1960. Price $10.50.

Reviewed by Miss Margaret E. Smith, VON, 1645 West 10th Ave., Vancouver 9.

"No person is well unless he is contented and able to take part in the world around him." "The usual purposes of recreation are enjoyment, individual fulfillment and enrichment of community living."

This is a text for the student of recreational therapy. It is also a guide for those who sense the potentialities of recreation in helping the handicapped fill their lives with satisfying, inspiring activities. These two themes are very concisely developed, always with the eye of insight on what is best for the patient and whether his reactions will help in his diagnosis or treatment.

The first section is for the administrator and the person planning a program. It deals with the philosophy of recreation and how to help the recreational therapist fit into the rehabilitation team.

The second section is an orientation to particular needs of patients and the medical indications for recreational therapy in specific illnesses. It includes a discussion of progressive activities in heart disease, cerebro-vascular accidents and tuberculosis; how recreation can build up strength and dexterity; how recreational therapy gives an opportunity to round out personality in motor handicaps, impaired senses, mental divergence, asocial behavior and psychopathology. The material is accurate and well-written. It shows a fine perception of the patient as a person rather than as a disease entity. It is a useful tool for the nurse who seldom has a recreational therapist to call on in the general hospital but who appreciates that her patient's mental and physical health could be stimulated by proper activity.

The last section discusses specific media such as music, art forms, literature, the theatre, crafts, hobbies, games and sports, parties and even details of how to square dance and to do various ballroom dances. In each instance the three levels of experience are illustrated: Exposure to the medium or *observation;* taking part or *participation;* and making something or *creating.* Some of the "do's" and "don'ts" and pitfalls are detailed from the authors' experience. This section also mentions the use of volunteer and community personnel, but stresses that someone must be responsible for over-all planning.

The emphasis is on the institutional situation with a recreational therapist in charge. However, the nurse in pediatrics, in geriatrics, in a nursing home or who is looking for activity for any group of patients will find specific suggestions which have been proven helpful by experience.

A Textbook of Pharmaceutical Arithmetic by Mervyn J. Huston, Ph.D. 109 pages. The Canadian Pharmaceutical Association, 221 Victoria Street, Toronto 1, Ont. 1959. Price $3.00.

Reviewed by Mrs. Margaret Wishlow, Instructor, Royal Columbian Hospital, New Westminster, B.C.

It is worth noting that this text is written by a professor in one of our Canadian universities. It is one of the comparatively few textbooks published in Canada. Professor Huston is Dean of the Faculty of Pharmacy, University of Alberta, Edmonton.

The purpose of this text is to serve as an introduction to pharmaceutical arithmetic. Based on the premise that the pharmacist must always be 100 per cent correct in his calculations, he must therefore have complete mastery of the arithmetic processes used in the practice of pharmacy. The pharmacist's responsibilities in preparing drugs and solutions and calculating doses is explained in detail. For practice purposes there are several pages of examples, problems and answers.

There is an excellent comparison of the apothecary and avoirdupois systems of weights, and of the Imperial (Canadian) and American systems of fluid measure. The metric system is also well presented. Conversions from one system to another are demonstrated using only actual equivalents and no approximate equivalents whatsoever. For nurses this method would prove very time-consuming and impractical.

Definitions and explanations of such terms as specific gravity, milligrams per cent, and proof strength are given. Their relationship to strengths of solutions is clarified. The comparison of the Centigrade and Fahrenheit thermometers is good. The list of abbreviations accepted and used in pharmacy is very helpful.

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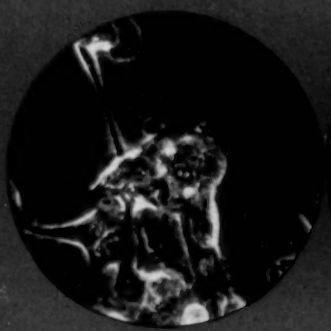
REFERENCES: 1. Hatjer, J.Y., and Pomerat, C.M.: In Vitro Observations on Behavior of Conjunctival and Corneal Cells in Relation to Electrolytes, Am. J. Ophthal. 46:369, 1958. (2) Pomerat, C.M., and Overman, R.R.: Electrolytes and Plasma Expanders, I. Reaction of Human Cells in Perfusion Chambers with Phase Contrast Time-Lapse Cine Records, Zeitschrift fur Zellforschung, Bd. 46 S 2-17, 1956. (3) Hild, W.: Ependymal Cells in Tissue Culture, Zeitschrift fur Zellforschung, Bd. 46 S 250-271, 1957. (4) Shambaugh, G.E.: Technical Problems in Surgical Treatment of Otosclerosis, J. Internatl. Coll. Surg. 26:772, 1956. (5) Elliott, K.A.C., and Jasper, H.H.: Physiological Salt Solutions for Brain Surgery. Studies of Local pH and Pial Vessel Reactions to Buffered and Unbuffered Isotonic Solutions, J. Neurosurg. 6:140, 1949.

WITHOUT TIS-U-SOL



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1960 INDEX

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This book would appear to accomplish its purpose. Although there is no mention made regarding the use of it by nurses, it would serve as a handy reference book for the pharmacology instructor.

Microbiology for Nurses by Martin Frobisher, B.S., Sc.D. and Lucille Sommermeyer, R.N., B.S., Ed.M. 562 pages. W. B. Saunders Company, West Washington Square, Philadelphia 5. 10th ed. 1960. Price $5.00.

Reviewed by Miss Grace Smith, Science Instructor, Royal Columbian Hospital, New Westminster, B.C.

In this 10th edition the authors state that their objective has been to make the book more useful and more convenient for both the teacher and the student. This has been accomplished by the method of presentation and the arrangement of informative subject matter; the use of tables which outline pertinent and factual material; summarization of information and a good selection of illustrations. Special attention is given to definitions and the derivation of words which may be new to the student. Each unfamiliar term is clearly and concisely explained as it occurs.

The individual units contain well-chosen subject matter. A section on the practical application of theory to nursing is conveniently placed at the end of many chapters. Supplementary reading lists and questions for review occur at the conclusion of each unit. The choice of questions tends to stimulate the student's interest and to help her in learning to correlate scientific material in a meaningful way.

The morphological and physiological properties of microorganisms which are outstanding in medicine and nursing are described by presenting distinctive and important characteristics. This general knowledge of microbiology makes the student aware of microorganisms and prepares her for the subsequent discussion of the methods of disinfection and sterilization. The historical note at the beginning of the unit is interesting and informative. Up-to-date methods of control are presented with a good choice of illustrative material.

The chapter on chemotherapy is well-arranged with summary tables for quick reference. An additional chapter on disinfection and sterilization in nursing concludes this unit and integrates the principles of asepsis with some important nursing procedures. There is one special section which serves as a good general review showing how blood is related to microbiology and infection. Specific resistance to infection, including the basic principles of immunology, is adequately covered.

The unit on pathogenic microorganisms is classified according to body tracts following a chapter on the modes of transmission of infection. Each important pathogen is described by a brief historical introduction; its physical properties; methods of laboratory investigation; control measures and their specific application to nursing. New material on viruses comprises nomenclature, groupings, transmission and immunization. The enteroviruses include recent discoveries concerning hepatitis viruses, Coxsackie viruses, ECHO viruses and polioviruses. Factual information is given in regard to the antibiotic — and heat-resistance of staphylococci. New material on helminths is presented. The concise tabular summarization of the common forms of intestinal worms is accurate and arranged for quick reference. This material resulting from recent research projects is an essential addition. It is well correlated with basic microbiological facts.

The last section is a summary of nursing responsibilities in transmissible diseases. It emphasizes the nurse's role in recognizing the interrelationships between nursing and the pathology department; in recognizing the need of skill and accuracy in assisting with treatments; and in recognizing the need for understanding the correlation with pharmacology in the prevention and control of transmissible conditions. The table showing the body fluids and discharges likely to carry infectious organisms is brief but it is excellent reference material for the student nurse early in her experience.

This book can be used as a text for student nurses at all levels and as a reliable reference source.

Microbiology and Pathology for Nurses by Martin Frobisher, Jr., S.B., Sc.D., Lucille Sommermeyer, R.N., B.S., Ed. M. and Raymond H. Goodale, B.S., M.D. 888 pages. W. B. Saunders Company, West Washington Square, Philadelphia 5. 5th ed. 1960. Price $7.50.

Reviewed by Mrs. Ruth Pollick, instructor, Winnipeg General Hospital.

This is a very comprehensive and informative study of these particular sciences. The first two sections detail microbiological facts and principles as a basis for techniques in medical and surgical asepsis. A third section deals with the destruction, removal and inhibition of microorganisms. Techniques of disinfection and sterilization are

defined and suggestions for their practical application to nursing are made. The principles of infection, immunity and allergy are considered. Finally the pathogens are described and studied according to their routes of transmission.

The section on pathology is presented under the headings of general, applied and clinical pathology. The nurse's responsibility for the collection and examination of specimens is stressed. The authors include a detailed discussion on the examination of body fluids, exudates and excretions.

A list of supplementary reading and a series of questions for review follow each unit. Diagrams, photographs, tables and charts supplement the printed word. The book is interesting, informative and a valuable reference for any nurse.

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— *The Financial Post*, October 8, 1960

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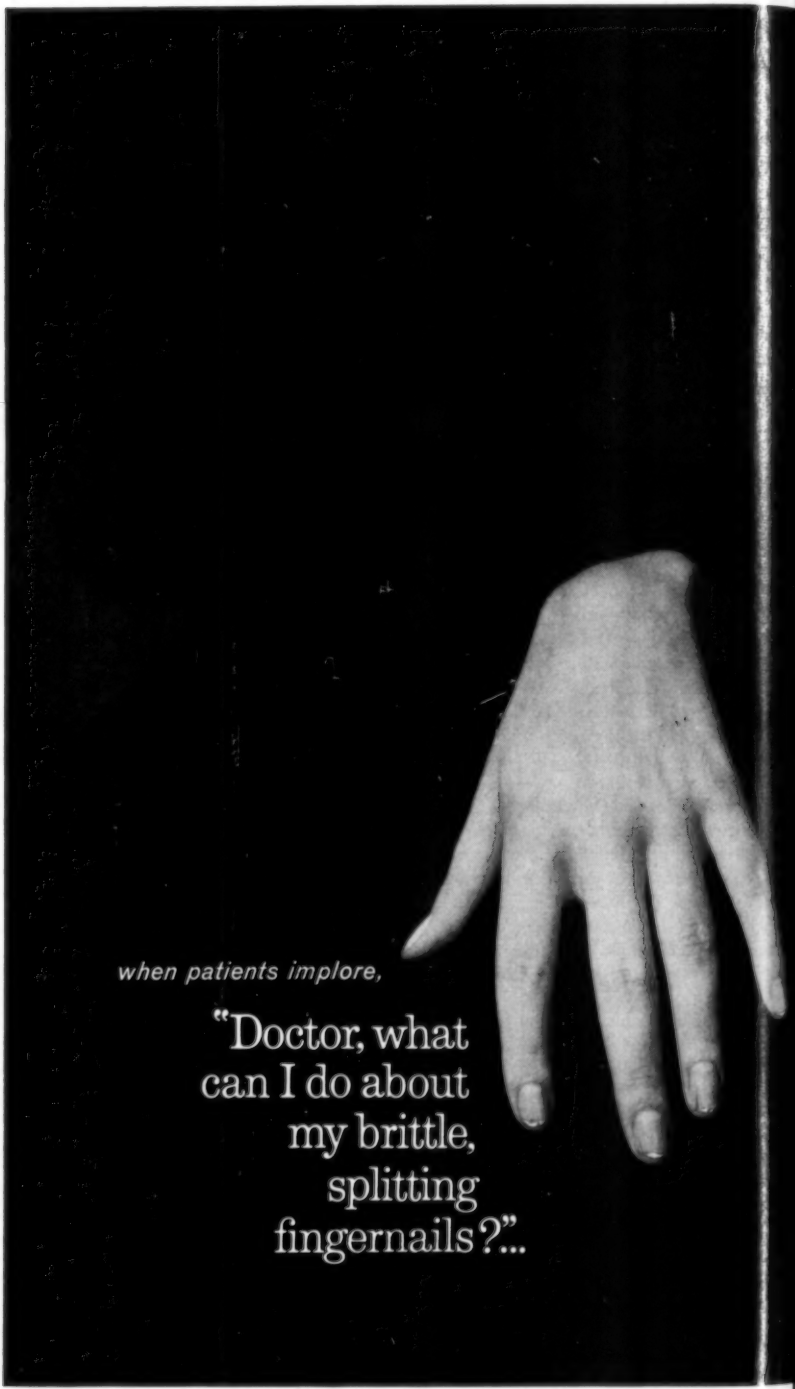
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1. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 78:330, September 1957. 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July 1957. 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955. 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.

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1. A.M.A. Journal of Diseases of Children 95: 109-119, 1958
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A Redefinition of Education

When we look realistically at today's world and become aware of what the actual problems of learning are, our conception of education changes radically. Although the educational system remains basically unchanged, we are no longer dealing primarily with the "vertical" transmission of the tried and true by the old, mature, and experienced teacher to the young, immature, and inexperienced pupil in the classroom.

This was the system of education developed in a stable, slowly changing culture. By itself, "vertical" transmission of knowledge no longer adequately serves the purposes of education in a world of rapid change.

What is needed and what we are already moving toward is the inclusion of another whole dimension of learning; the "lateral" transmission, to every sentient member of society, of what has just been discovered, invented, created, manufactured, or marketed.

This need for "lateral" transmission exists no less in the classroom and laboratory than it does on the assembly line with its working force of experienced and raw workmen. The man who teaches another individual the new mathematics or the use of a newly invented tool is not sharing knowledge he acquired years ago. He learned what was new yesterday, and his pupil must learn it today.

In today's world, no one can "complete an education." The students we need are not just children who are learning to read and write, plus older students, conceived of as minors, who are either "going on" with or "going back" to specialized education. Rather, we need children and adolescents and young and mature and "senior" adults, each of whom is learning at the appropriate pace and with all the special advantages and disadvantages of experience peculiar to his own age.

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In this world, the age of the teacher is no longer necessarily revelant. For instance, children teach grandparents how to manage TV, young expediters come into the factory along with the new equipment, and young men invent automatic programming for computors over which their seniors struggle.

This is what we call the "lateral" transmission of knowledge. It is not an outpouring of knowledge from the "wise old teacher" into the minds of young pupils, as in "vertical" transmission. Rather, it is a sharing of knowledge by the informed with the uninformed, whatever their ages. The primary prerequisite for the learner is the desire to know.

— MARGARET MEAD,
National Education Association Journal

* * *

Cigarette smoking speeds up the clotting of blood and increases the toughness of the clot, according to recent studies at the University of Pennsylvania Hospital, Philadelphia.

The blood of all volunteers, five men and five women, after smoking one standard non-filtered cigarette of high nicotine content, formed clots of greater tensile strength and in a shorter time than blood drawn before smoking.

— *Heart Research Newsletter*

* * *

About ten years before retirement from business is a good time to start planning for the long time of leisure, which could become boring unless there is a constructive program. If finances will be short, any marketable talent should be improved through study and instruction. There are many jobs where the retired expert can be used for part-time work.

— Dept. of National Health and Welfare,
Ottawa

* * *

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— EDWIN A. ROBINSON

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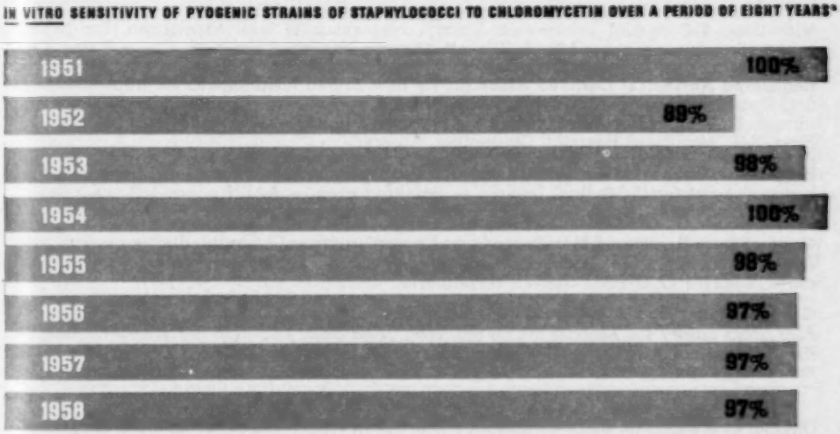

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References: (1) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* 82:513, 1960. (2) Editorial Comments: *Canad. M. A. J.* 82:537, 1960. (3) Brownrigg, G. M.: *Canad. M. A. J.* 73:787, 1955. (4) Roy, T. E.; Collins, A. M.; Craig, G., & Duncan, I. B. R.: *Canad. M. A. J.* 77:844, 1957. (5) Royer, A., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783.

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Registered Nurses, Certified Nursing Assistants for modern 75-bed hospital. Starting salary: R.N.'s $300 per mo. with merit increases after 6-mo. service, C.N.A.'s $216 per mo. Single room residence accommodation available. Attractive growing town of 5,500 midway between Winnipeg & Fort William on the main line of the C.P.R. & on the Trans-Canada Highway in the midst of large tourist area. For information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing District General Hospital, Dryden, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $300 & $210 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Hospital of Ontario pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses for General Duty (2) urgently needed for 48-bed hospital. Highest salary paid. Telephone 378 or reply to: The Administrator of St. Joseph's General Hospital, Little Current, Ontario.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES

OPPORTUNITIES

REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, AND CERTIFIED AUXILIARY NURSES

for positions in Hospitals, Outpost Nursing Stations and Health Centres in the Provinces, Eastern Arctic, Northwest and Yukon Territories.

SALARIES

(1) Public Health Nursing Supervisor II —$5,100 to $5,460 per annum

(2) Public Health Nursing Supervisor I —$4,620 to $5,160 per annum

(3) Directors and Assistant Directors of Hospital Nursing Services:

- a) Classification III —$4,860 to $5,400 per annum
- b) Classification II —$4,350 to $4,860 per annum
- c) Classification I —$3,900 to $4,560 per annum

(4) Public Health Staff Nurses —$3,600 to $4,050 per annum

(5) Hospital Staff Nurses —$3,300 to $3,750 per annum

(6) Certified Nursing Assistants, Licensed Practical Nurses and Nurses' Aides: up to $2,400 per annum depending upon qualifications and location of positions.

- Room, board and laundry in residence at reasonable rates. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.
- Special pay and leave allowances for those posted to isolated areas.

For interesting, challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 705 Commercial Building, 169 Pioneer Avenue, Winnipeg 1, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

(or) Chief, Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $290-$335. 28-day vacation after 1-yr. C.N.A. salary $210-$240, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience, $5.00 increment every 6-mo., 40-hr. wk., 8 statutory holidays. Room & board residence $28.50 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses for General Duty in all departments including premature & new-born nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty in modern 18-bed Private Hospital, in iron mining town, 150-mi. north of Sault Ste. Marie, Ontario. Starting salary $281 min. to $316 max. for experience, less $20 per mo. for maintenance. Excellent accommodations & personnel policies, transportation allowance after 6-mo. service. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $285 per mo.** with annual merit increments, **plus annual bonus plan.** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered Nurse for Operating Room. Responsible for supervising operating room & Central Supply Dept. in small sized hospital. Good personnel policies, living-in accommodation if desired, pension plan. Apply to: Superintendent, District Hospital, Kemptville, Ontario.

Registered Staff Nurses for Operating Room Department: A new, well equipped unit; rotating hours of duty; attractive personnel policies. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses & Certified Nursing Assistants for modern 50-bed active hospital, 40-hr. wk. with all statutory holidays, pension plan & sick leave benefits. Meaford is situated on Georgian Bay & is an all year resort town. For further information apply to: Director of Nursing Services, General Hospital, Meaford, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $285, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing. Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $270 monthly, Graduates at $250; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing. Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $285 per mo. with recognition for P.G. courses, 40-hr. wk. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; $285 gross. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital Tillsonburg, Ontario.

General Duty Nurses for 350-bed General Hospital located in downtown Toronto — Rotating hours of duty, attractive personnel policies, in-service education program. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays, full particulars, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

THE VANCOUVER GENERAL HOSPITAL

Appointments to nursing positions are available.

Good personnel policies in effect including medical welfare plan, 40 hour week — four weeks' vacation.

Salary $297 - $359 per month
with consideration for experience or special preparation.

Please apply to:

PERSONNEL DEPARTMENT,
10TH AVENUE AND WILLOW STREET,
VANCOUVER 9, BRITISH COLUMBIA.

THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO:

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL
WINNIPEG 3, MANITOBA

Graduate Nurses, Nursing Assistants for General Duty for new 58-bed hospital, 40-hr. wk., 8 statutory holidays, 3-wk. vacation after one year service, Pension Plan. Nurses' salary $270 - $300, Nursing Assistants $175 - $205. For information write to: The Superintendent, Prince Edward County Memorial Hospital, Picton, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Public Health Nurses (Qualified) Generalized program includes some bedside nursing. Salary $3,500 - $4,500; annual increment $200, 5-day wk., car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ontario.

Nurses (2) for United Church Mission Hospital in northern British Columbia. Salary $285 per mo. An opportunity for Christian service. Apply: Wrinch Memorial Hospital, **Hazelton, British Columbia, or** Dr. M. C. Macdonald, Board of Home Missions, United Church, 85 St. Clair Avenue East, **Toronto, Ontario.**

P.E.I.

Director Public Health Nursing, Provincial (100,000 population), qualified and experienced in supervision & administration. Apply giving reference etc. to: Director, Public Health Nursing, Box 3000, Charlottetown, P.E.I.

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at £46-0-0 per mo. with full maintenance. Transportation allowance. For full particulars apply: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Clinical Instructor in Rehabilitation Nursing and Rehabilitation Nurse for expanding program in a New England rehabilitation facility. Full details upon request. Write Box N, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for modern 60-bed General Hospital, 40-mi. south of Montreal. Salary $275 per mo. 5 semi-annual increases; monthly bonus for permanent evening & night shifts, 44-hr. wk., 4-wk. vacation. Accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Nursing Superintendent for modern, accredited 60-bed hospital. Living accommodation available. Apply stating qualifications & salary expected to: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Registered General Duty Nurses for 28-bed General Hospital 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays; 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

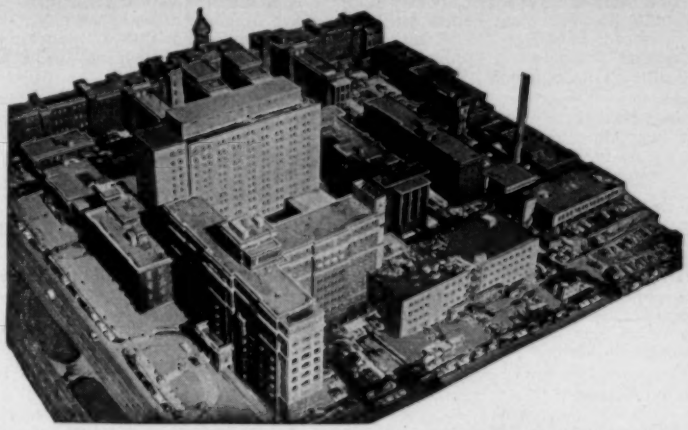
SASKATCHEWAN

Registered Nurses for General Duty for 24-bed hospital, a new 34-bed hospital presently under construction. Present hospital to be converted to a nursing home for the aged. Salary schedule $290-$350 gross, $10 increments every 6-mo. Living ahsommodation available in new residence. T.V. set, board & lodging $34.50 per mo., 3-wk. vacation after 1 year service. 8 statutory holidays, 1½ days sick leave accomulative up to 90-days, 40-hr. wk., bus service daily to major city. Apply to: Secretary-Manager, Union Hospital Leader, Saskatchewan.

Registered Nurses for 80-bed General Hospital (expanding to 100-beds). General Duty Nurses & Supervisors required. With Saskatchewan registration basic salaries $280, & $336 respectively with recognition for P.G. courses, university training, & previous experience. Forty (40) hr. work wk., good personnel policies. Residence accommodation & meals if desired. Apply to: Director of Nurses, Union Hospital, Weyburn, Saskatchewan.

U.S.A.

Operating Room Supervisor for 238-bed JCAH approved hospital. Intern, Resident & Nursing Education programs. Candidates with BS degree preferred. Apply to: Mrs. Virginia Krahl, Director of Nursing Service, Cottage Hospital, 320 West Pueblo Street, Santa Barbara, California.



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for Medical and Surgical Services

including newly opened Neurosurgical and Cardiovascular Units

Rewarding Experience — Excellent Personnel Policies

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Director of Nursing, Toronto General Hospital, 101 College Street, Toronto 2, Ontario

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Modern Hospital and School of Nursing

Active in-Service Program

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DIRECTOR OF NURSING, SUDBURY GENERAL HOSPITAL, SUDBURY, ONTARIO.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses (Come to sunny California) **Staff Nurses for permanent positions,** various departments, days, eves, nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses excellent opportunities. Progressive 440-bed General Hospital, expanding to 525-beds in early 1961. Expansion is creating openings in all areas. Salary range $370 - $400 per mo., $25 P.M. & night differential. $25 additional for surgery. Liberal vacation plan, 7 paid holidays, 40 hr. wk. health insurance & retirement plan. Close to all summer & winter, mountain & ocean activities. Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $335 - $395, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered, General Duty & Operating Room Nurses for modern 74-bed District Hospital, midway between San Francisco & Los Angeles, California. Starting salary $350 per mo., 40-hr. wk., living quarters available. Contact: Administrator, District Hospital, 869 Cherry Avenue, Tulare, California.

Registered Nurses for General Duty in modern, accredited 76-bed hospital — South Central California near Sequoia National Park. Good salary & benefits. Excellent working conditions. Ideal community. Winter & Summer recreation Transportation to hospital paid on suitable confirmation of employment. Must qualify for registration in California. For details write: Administrator, Memorial Hospital at Exeter, 215 Crespi Avenue, Exeter, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro, area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $4,320 to $5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Duty Nurses for 72-bed hospital located in college town in mountainous portion of Colorado. Salary $350 per mo. with periodic increases, fringe benefits — including meals, sick leave, vacation, etc. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered Nurses — Excellent opportunities for Staff Nurses in large hospital. Salary range for permanent evenings & nights $420-$450, rotating range $390 - $420. Private room accommodation at reasonable rates. Centrally located. Convenient transportation. Write to: Director of Nursing Service, Dept. A.J.N., Mount Sinai Medical Center, 2750 West 15th Place, Chicago 8, Illinois.

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Opportunities for

PROFESSIONAL NURSES

Positions available in all Clinical Areas

(1) Obstetrical Unit

Apply to:
SUPERINTENDENT OF NURSING,
MOUNT HAMILTON HOSPITAL,
CONCESSION STREET,
HAMILTON, ONTARIO.

(2) Medical Unit

Apply to:
SUPERINTENDENT OF NURSING,
NORA-FRANCES HENDERSON HOSPITAL,
CONCESSION STREET,
HAMILTON, ONTARIO.

(3) Medical - Surgical - Pediatric Unit & Operating Room

Apply to:
DIRECTOR OF NURSING,
HAMILTON GENERAL HOSPITAL,
BARTON STREET EAST,
HAMILTON, ONTARIO.

Personnel Policies sent on request.

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Niagara Falls - Ontario

APPLICATIONS ARE INVITED FOR THE POSITION OF

Rotating Supervisor
(evening and night)

NEW HOSPITAL;
GOOD PERSONNEL POLICIES.

For further information apply to:

THE DIRECTOR OF NURSING
THE GREATER NIAGARA GENERAL HOSPITAL,
NIAGARA FALLS, ONTARIO

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offers interesting and challenging positions in
OUTPOST NURSING
PUBLIC HEALTH NURSING
BLOOD TRANSFUSION SERVICE

Salaries are in proportion to experience and qualifications.

Transportation arranged under certain circumstances.

Bursaries available for postgraduate studies.

Group insurance, pension plan and other benefits.

For information please contact:
NATIONAL DIRECTOR, NURSING SERVICES,
THE CANADIAN RED CROSS SOCIETY
95 WELLESLEY STREET EAST,
TORONTO 5, ONTARIO

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Registered Nurses willing to serve as volunteer Home Nursing Instructors will be welcomed by the Red Cross Branch in your community.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Staff Nurses & Licensed Practical Nurses (Openings in several areas, all shifts.) 37½-hr. work wk., in small community hospital, 2-mi from Boston. Living quarters available. Minimum starting pay $70 R.N.'s., L.P.N.'s $58 per wk. Experience considered, diferentials for reliefs, nights. Contact: Director of Nurses, Chelsea Memorial Hospital, Chelsea, Massachusetts.

Registered Nurses: Transportation Paid via 1st class air to Albuquerque & return in exchange for 1-yr. employment contract. Come to New Mexico, "Land of Enchantment", largest private hospital in state — General Hospital, sanatorium & geriatric units, building program, in-service education. Vacancies for staff duty, salary $300/mo. to start, $15 differential for evenings & nights. Write or call: Mrs. Emily J. Tuttle, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Supervisors — Medical-Surgical, Pediatrics, Obstetrics & Psychiatric. Base salary $400 to $439, depending upon preparation & experience. Liberal personnel policies include sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs. Housing available on campus or in vicinity of hospitals. Apply: Director Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies include sick leave retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

General Duty & Operating Room Nurses for 210-bed General Hospital. Start $335 days, $360 evenings, $355 nights, plus $10 for O.R., university city, 40-hr. wk., 7 holidays, extended vacations, sick leave benefits, free Blue Cross hospital-medical insurance & $2,500 life insurance, retirement program plus Social Security, extensive Intern-Resident Educational Program, living quarters available. Write, Personnel Manager, Virginia Mason Hospital, 1111 Terry Avenue, Seattle 1, Washington.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

Registered Nurses & Certified Nursing Assistants for immediate & future vacancies in this 42-bed hospital. Starting salary $300 & $210 respectively. Deduction for room & board $40. Excellent personnel policies. For full information apply to: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Residence, Cook County School of Nursing

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COOK COUNTY HOSPITAL

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Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at $345-$385 for a 37½ hour week. And you're only minutes from Chicago's fabulous Loop and local universities

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

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Write:

DIRECTOR OF NURSING SERVICE,
DUKE UNIVERSITY MEDICAL CENTER HOSPITAL,
DURHAM, NORTH CAROLINA.

DIRECTOR OF NURSING

Applications are invited for this position in a new 82-bed hospital. This opportunity promises hard work, good pay, a good staff to work with, a good town to live in, a challenge to any aspiring head nurse or supervisor.

Residence suite available.

Write:

ADMINISTRATOR,
KITIMAT GENERAL HOSPITAL,
BOX 1700, KITIMAT, B.C.

AN EXTENSION COURSE IN NURSING UNIT ADMINISTRATION

Those nurses who are interested in enrolling for the Extension Course in Nursing Unit Administration should submit their applications not later than April 30th, 1961. Applications will be accepted from nurses who are engaged in positions of assistant head nurses, head nurses or supervisors and who are unable to attend a university school of nursing. Directors of nurses in small hospitals may also enroll.

The course will start with a workshop in September to be followed by a seven month period of home study. A final workshop will be held in May 1962.

This course is jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association.

Information and application forms may be obtained by writing to:

DIRECTOR, EXTENSION COURSE IN NURSING UNIT ADMINISTRATION, 25 IMPERIAL STREET, TORONTO 7, ONTARIO.

DIRECTOR OF NURSING

Director of Nursing wanted. Modern 750-bed accredited civic General Hospital (200-bed addition being built). Responsible position. To plan and direct education of (300) Student Nurses and service programs. Perquisites include suite with service, pension plan, four (4) weeks vacation, sick benefits. Salary $7,000 - $9,000 annually depending upon qualifications and experience. Duties to commence as soon as possible.

Address replies to:

CHAIRMAN, CALGARY HOSPITALS BOARD, CALGARY GENERAL HOSPITAL, CALGARY, ALBERTA.

HEAD NURSE

required by

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For supervision of nursing services in a small hospital and out-patient clinic. Duties will also involve supervision of educational procedures for nursing groups outside the institution.

Candidates should have postgraduate training in psychiatry and experience in psychiatric nursing.

Salary approximately in accordance with Registered Nurses' Association of Ontario.

Applications should be directed to:

MEDICAL DIRECTOR, ALCOHOLISM RESEARCH FOUNDATION, 24 HARBORD STREET, TORONTO 5, ONTARIO.

DIRECTOR OF NURSING

Position open in well equipped modern 111-bed hospital. U.B.C. School of Nursing affiliation. Administration courses advantageous but not essential. Salary commensurate with experience and qualifications. Submit application with complete information and references to:

MR. H. E. TAYLOR, ADMINISTRATOR, WEST COAST GENERAL HOSPITAL, PORT ALBERNI, VANCOUVER ISLAND, BRITISH COLUMBIA.

GRADUATE NURSES

and

Certified Nursing Assistants

required for

FIVE SUMMER CAMPS

STRATEGICALLY LOCATED
THROUGHOUT ONTARIO
AND NEAR:
OTTAWA - LONDON
COLLINGWOOD
PORT COLBORNE
KIRKLAND LAKE

Apply in writing to:

Miss Helen Wallace, Reg'd N.
SUPERVISOR OF CAMPS
ONTARIO SOCIETY FOR CRIPPLED CHILDREN
92 COLLEGE STREET
TORONTO, ONTARIO

BURLINGTON, ONTARIO

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

are needed for

a new 225 bed hospital

to be opened

February 1961

For information, write to:

DIRECTOR OF NURSING
JOSEPH BRANT MEMORIAL HOSPITAL
1240 NORTH SHORE BLVD.,
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GUELPH GENERAL HOSPITAL

Active — 200 beds — Fully Accredited

Requires

GENERAL STAFF NURSES

Pleasant city of 38,000 close to larger centers

Excellent salary and personnel policies

For further details apply to:

THE DIRECTOR OF NURSING,
GENERAL HOSPITAL,
GUELPH, ONTARIO.

McKELLAR GENERAL HOSPITAL

School of Nursing

will have openings for

INSTRUCTORS

in Medicine, Surgery and Pediatrics

by July 15th, 1961

Qualified applicants are invited to apply:

Salary commensurate with experience and qualifications.

Apply to:

DIRECTOR,
McKELLAR GENERAL HOSPITAL,
FORT WILLIAM, ONTARIO.

JEWISH GENERAL HOSPITAL

MONTREAL, QUEBEC

Completion of expansion program makes available attractive positions for Registered Nurses for General Duty and also for Certified Nursing Assistants. Head Nurse and Assistant Head Nurse positions are also available in Medical and Surgical Nursing Units. Instructor with post basic preparation in Nursing Education required for School of Nursing. Excellent personnel policies. Salary in accordance with the Association of Nurses of the Province of Quebec recommendations and commensurate with experience and education.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL
3755 COTE ST. CATHERINE ROAD, MONTREAL, QUEBEC

SCHOOL OF NURSING ADVISER

APPLICATIONS ARE INVITED BY

The New Brunswick Association of Registered Nurses.
Qualifications required: a degree in nursing, senior experience in nursing education and nursing service. Personnel policies include pension plan. Terms of reference available on request.

Apply to: The Executive Secretary

THE NEW BRUNSWICK ASSOCIATION OF REGISTERED NURSES
231 SAUNDERS STREET — FREDERICTON, N.B.

REGISTERED NURSES

(SUPERVISORS)

Day and evening Supervisors required for Clearwater Lake Hospital, The Pas. 150 beds for tuberculosis and extended treatment patients. Good working conditions and excellent personnel policies. Salary schedule $330-$340 per month.

For information and application apply:

DIRECTOR OF NURSING SERVICES,
SANATORIUM BOARD OF MANITOBA,
1654 PORTAGE AVENUE, WINNIPEG 12, MANITOBA.

ASSISTANT DIRECTOR

Applications are invited for an Assistant Director of the Extension Course in Nursing Unit Administration. This course is jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association.

Qualifications: University preparation in teaching and supervision is necessary with several years experience in a supervisory position. Fluency in the French Language is desirable but not necessary.

For further information write to:

Director, Extension Course in Nursing Unit Administration,
25 IMPERIAL STREET, TORONTO 7, ONTARIO.

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NURSES NEEDED

Salary, according to qualifications: $57.00 - $90.00 per week.
Evening differential: $7.00 per week. — Night differential: $5.00 per week.
Increases: After 6 months, 1 year, 2 years.
Free: Two meals daily — Laundering of uniforms.
Statutory holidays - 10 days; Paid sick time - 2 weeks (after 1 year)
Paid vacation: 3 weeks after 1 year, Pension plan.
Opportunities for promotion — Inservice education program.

For further information, write to:

LA DIRECTRICE DU NURSING — HOPITAL NOTRE-DAME — MONTREAL

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

OPERATING ROOM NURSES

For a 187 bed General Hospital. 40 hour work week with 2 weeks paid vacation and one day per month paid sick leave. Salary $385 a month plus $1.00 per hour for call and time and one-half for overtime. Substantial raise in 6 months, $25 a month differential for 3-11 p.m. and 11-7 shifts. Medical-hospital insurance paid after 6 months employment. Air conditioned surgery. Close to downtown shopping and transportation. Good living facilities in immediate neighborhood.

WRITE:

DIRECTOR OF NURSING SERVICE, THE DOCTORS HOSPITAL, 909 UNIVERSITY STREET, SEATTLE, WASHINGTON.

GENERAL DUTY NURSES

for all departments in a new 107 bed hospital.

Gross salary for Registered Nurses - $295, 40 hour week, 3 weeks vacation annually. Group pension plan and residence accommodation if desired.

Apply: Director of Nursing,

ST. JOSEPH'S GENERAL HOSPITAL, ELLIOT LAKE, ONTARIO.

TORONTO GENERAL HOSPITAL

NURSING SERVICE DEPARTMENT

is considering applications

for

SUPERVISORS

Rotation through the three tours of duty required. Preparation in nursing service administration and at least five years' experience in nursing necessary.

Applications may be obtained by writing to:

ACTING DIRECTOR OF NURSING, TORONTO GENERAL HOSPITAL, 101 COLLEGE STREET, TORONTO, ONTARIO.

KINGSTON GENERAL HOSPITAL

requires

GENERAL DUTY NURSES

for:

Medical, Psychiatric, Surgical Floors and Intensive Care Unit (male or female Registered Nurses considered for all above positions)

Certified Nursing Assistants

Trained psychiatric attendants (F)

For full details relating to hours, vacations and benefits, apply to:

DIRECTOR OF NURSING, KINGSTON GENERAL HOSPITAL, KINGSTON, ONTARIO

HEALTH EDUCATION BURSARY

REQUIREMENTS

1. Baccalaureate degree with preparation in public health and education. Education courses may be supplemented at summer school prior to fall admissions. Must have high scholastic standing to meet the admission requirements of the University of Michigan or California.
2. At least 3 years professional experience.
3. Three letters of recommendation. We are only interested in true leaders.
4. A personal interview must be arranged by you at the OTA office.
5. At least 2 years service with the OTA following the course. Must be free to travel throughout the province and to locate in a specified region in order to develop the health education program.

Amount:

Bursary $3,600; Salary $4,800 minimum plus expenses.

Apply:

MISS FLORIS E. KING, B.Sc.N., M.P.H., HEALTH EDUCATION CONSULTANT, ONTARIO TUBERCULOSIS ASSOCIATION, 3050 YONGE ST., TORONTO 12, ONT.

VICTORIA HOSPITAL

LONDON, ONTARIO

Modern 900-bed hospital

requires

Registered Nurses for all services

and

Certified Nursing Assistants

40 hour week - pension plan - good salaries and personnel policies.

Apply:

DIRECTOR OF NURSING VICTORIA HOSPITAL LONDON, ONTARIO.

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $270-$320 per mo. Certified Nursing Assistants $200-$220 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

REGISTERED NURSES
NURSING ASSISTANTS

Required for all departments in new 160-bed hospital, centrally located between Toronto and Hamilton, in a very progressive community.

Good salary and personnel policies, pension plan, 40-hour week.

Apply stating age, qualifications to:

DIRECTOR OF NURSING,
OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL, OAKVILLE, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $285-$315 monthly ($131.20 - $145 bi-weekly) $265 monthly ($122 bi-weekly) until registered. Rotating periods of duty — 40 hour week, 8 statutory holidays, annual vacation 21 days. Annual sick time 12 days, cumulative to 18 days. Hospitals of Ontario, Pension plan, Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

(1) Administrative Supervisor for Operating Room

(2) General Duty Staff for hospital.

For further information write:

THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $280 to $320 gross per month. Differential for evening and night duty. Temporary residence accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL, SASKATOON, SASKATCHEWAN

NURSING CONSULTANT (HOSPITAL INSURANCE)

required by

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

OTTAWA

$7,500 - $8,700

Duties will involve advising on nursing services as related to hospital services in Canada, acting as consultant to provincial health and hospital insurance authorities on nursing aspects related to hospital services within the provinces and developing plans and techniques for the improvement of nursing services in hospitals.

Candidates must possess a Baccalaureate Degree in Nursing, registration in a province of Canada, at least ten years of acceptable experience, some in positions of leadership, and a broad knowledge of nursing in Canadian Hospitals.

For details, write to

CIVIL SERVICE COMMISSION, OTTAWA

Please ask for Information Circular 60-897.

SUPERVISOR

required for

A medical unit in a General Hospital, 434-beds, with a School of Nursing.

For further information write:

DIRECTOR OF NURSING ROYAL COLUMBIAN HOSPITAL, NEW WESTMINSTER, B.C.

PUBLIC HEALTH NURSES

Applications are invited from Graduate Nurses holding a Diploma in Public Health Nursing or equivalent, for positions in Nova Scotia.

Salary $3,150 to $4,200, depending upon experience; uniforms are provided; cars are provided or mileage paid; Civil Service and Superannuation benefits.

For further information and Application Forms, Apply to:

DIRECTOR, DIVISION OF PUBLIC HEALTH NURSING, DEPARTMENT OF PUBLIC HEALTH, BOX 488, HALIFAX, NOVA SCOTIA.

ASSOCIATE DIRECTOR OF NURSING

CALGARY GENERAL HOSPITAL

invites applications for the position of Associate Director of Nursing, Modern 750-bed accredited civic General Hospital (200-bed addition being built). Duties to commence as soon as possible. Salary range $5,000 - $6,500 per year depending upon qualifications and experience. Liberal benefits and personnel policies.

Address replies to:

ADMINISTRATOR, CALGARY GENERAL HOSPITAL, CALGARY, ALBERTA.

NORTH BAY ONTARIO

Graduates of St. Joseph's Hospital School of Nursing Alumni are requested by their Alumni to please forward their addresses to:—

MRS. GORDON WHITE, 373 McINTYRE STREET EAST, NORTH BAY, ONTARIO.

SUPERINTENDENT OF NURSES

FOR

CLEARWATER LAKE HOSPITAL

THE PAS, MANITOBA

Well equipped 160-bed hospital with general and tuberculosis patients. Salary range $355-$400 per month, commensurate with experience and qualifications. Good residence accommodation and excellent personnel policies.

For information and application apply:

DIRECTOR OF NURSING SERVICES,
SANATORIUM BOARD OF MANITOBA,
1654 PORTAGE AVENUE, WINNIPEG, MANITOBA.

EDUCATIONAL DIRECTOR

FOR NEW SCHOOL OF NURSING

New school building, new student residence. Hospital opened in 1956, all services; 250-beds.

Present plan to enrol first class of students for September 1961. Director required at once to facilitate planning an educational program and arranging for staff.

Opportunities for additional education at Laurentian University.

Salary according to qualifications and experience.

Apply:

DIRECTOR OF NURSING, SUDBURY MEMORIAL HOSPITAL,
REGENT STREET SOUTH, SUDBURY, ONTARIO.

THE SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL

REQUIRES

INSTRUCTOR IN PEDIATRIC NURSING

This is an opportunity to be a member of the faculty in a progressive school which emphasizes educational experiences for the student in a program pattern of two years of nursing education followed by one year internship. One class of 30 students is admitted yearly. Duties include clinical and classroom instruction.

Requirements: University preparation in Nursing Education
Salary differential for degree.

For further information apply to:

DIRECTOR, SCHOOL OF NURSING, 2240 KILDARE RD., WINDSOR, ONT.

GENERAL DUTY NURSES (2)

FOR A MODERN, NEW 25-BED HOSPITAL

3 doctors on staff. 9 Registered Nurses, 3 Nursing Assistants, 1 Laboratory Technician, 1 X-Ray Technician. 5 day 40-hour week. No split shifts, 3 weeks vacation after one year service, 9 statutory holidays. Salary $280-$380. Single rooms in modern nurses' residence with television. Board and room $1.15 per day, laundry free. Established personnel policies. Apply in writing to:

JANIE SUTHERLAND, SUPERINTENDENT OF NURSES,
UNION HOSPITAL, P.O. BOX 760, ESTON, SASKATCHEWAN.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies.
APPLY TO: DIRECTOR OF NURSING,
HALDIMAND WAR MEMORIAL HOSPITAL,
DUNNVILLE, ONTARIO

OTTAWA CIVIC HOSPITAL

requires

GENERAL STAFF NURSES

for

OPERATING ROOM
MEDICAL
SURGICAL & OBSTETRICAL } DEPARTMENTS

Apply

EDITH G. YOUNG, REG.N.,
ASSISTANT ADMINISTRATOR - NURSING

THE GENERAL HOSPITAL OF PORT ARTHUR

Invites applications from

Registered Nurses for General Staff positions.

Excellent personnel policies.

For further information write:

THE DIRECTOR OF NURSING
THE GENERAL HOSPITAL OF PORT ARTHUR
PORT ARTHUR, ONTARIO.

GENERAL DUTY NURSES

WANTED

Salary — $265 - $315 per month 40-hour week, no split shifts.

Vacation — 3 weeks after one year; statutory holidays — eight (8); sick leave — cumulative from date of employment.

Transportation — advanced on repayable basis For 75-bed fully accreditated hospital built in 1956, located in south-western Ontario.

Apply to: Director of Nursing,

SYDENHAM DISTRICT HOSPITAL
WALLACEBURG, ONTARIO

WOMAN'S HOSPITAL

invites you to
Further your Nursing Experience
Opportunities open for
GRADUATE NURSES
in all areas
Liberal personnel policies
Hospital within walking distance of
Wayne State University
Every effort is made to provide the opportunity for each nurse to reach her potential
Must be eligible for registration in the State of Michigan

Write:

WOMAN'S HOSPITAL,
PERSONNEL DEPARTMENT
432 E. HANCOCK
DETROIT 1, MICHIGAN

PUBLIC HEALTH NURSES

REQUIRED FOR HEALTH BRANCH
B.C. CIVIL SERVICE

Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY $346-$405 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, write to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C.

COMPETITION NO. 60:484.

REGINA GENERAL HOSPITAL
School of Nursing

requires

CLINICAL INSTRUCTORS
in Obstetrical, Surgical and Communicable Disease Nursing.

S.R.N.A. salary scales apply.

Apply to:

Associate Director, Nursing Education,
School of Nursing,
Regina General Hospital,
Regina, Saskatchewan.

GENERAL DUTY NURSES WANTED

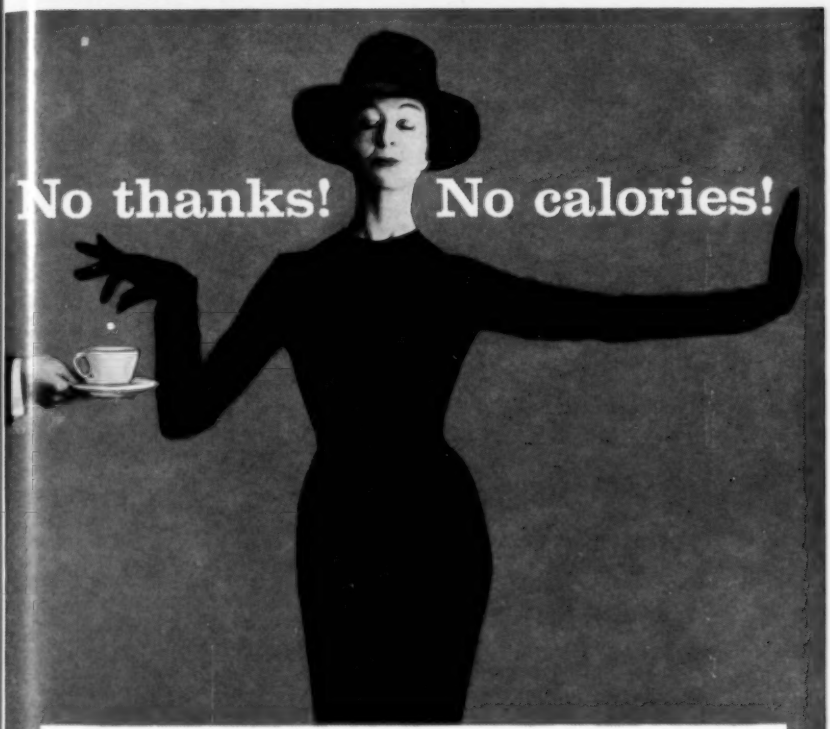
Salary - $300 to $320 per month 40 hour week, no split shifts.

Vacation - 18 days plus 10 statutory holidays a year, 21 days sick leave cumulative from time of employment.

Transportation will be advanced if necessary.

Apply: Matron,

BERWYN MUNICIPAL HOSPITAL,
BERWYN, ALBERTA.



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